RURAL HEALTH CLINIC
RHC CERFICATION
SPRING, 2019

Thank you for engaging Healthcare Business Specialists to help you convert your clinic into a rural health clinic. We have prepared this document as a listing of steps required to be completed before the survey. We will help you with the RHC Emergnecy Preparedness Policy and Procedure Manuals by drafting up these manuals for your review. There are a number of processes that need to be started before the survey in order to pass the inspection with as few deficienices as possible. Please review the following report and assign the duties to the staff of the RHC as indicated by the image on each page of the forms.

Healthcare Business Specialists

Specializing in RHC reimbursement

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RHC CERTIFICATION TO DO LIST
PLEASE INDICATE WHEN COMPLETED WITH A CHECKMARK

MEDICAL DIRECTOR DUTIES

	Review and sign and date the Policy and Procedure Manual and Annual Evaluation
	Review 15 charts for each NP/PA using a special form or at least list 10 charts you reviewed and sign and date the form along with the NP/PA.
	Sign and Review Collaborative agreement with NP/PA
	Review and sign the Emergency Preparedness Manual, participate in drills.
	Determine which Emergency drugs will be in the Emergency Kit.

NURSE PRACTITIONERS AND PHYSICAN ASSISTANTS

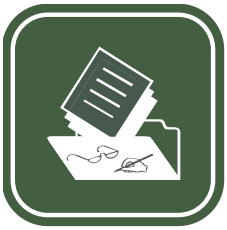
	Review and sign and date the Policy and Procedure Manual and Annual Evaluation
	Sign and Review Collaborative agreement with NP/PA
	Review and sign the Emergency Preparedness Manual, participate in drills.
	Keep a schedule of Nurse practitioners for review by the surveyors (50% rule)
	Determine which Emergency drugs will be in the Emergency Kit.

NURSING AND MEDICAL ASSISTANTS

	See Nursing Checklists for Monthly duties
	Clean up areas. Remove clutter. Remove anything with an expired expiration date.
	Undergo OSHA Training, Airborne pathogens, Emergency Preparedness.
	Perform six required lab tests and document controls.
	Remove any hazards from patient rooms. See walk through summary sheet.

OFFICE MANAGER AND ADMINISTRATION

	Prepare Evidence Binder for State Inspection
	Work with HBS to get RHC, OSHA, Lab, HIPAA, and EP Policy and Procedure Manuals
	Arrange for Emergency Preparedness to be completed (work with HBS)
	Arrange for preventive maintenance of patient equipment
	Credential providers and all licensed personnel, update CPR, BLS, etc.



ANNUAL PROJECTS AND REQUIREMENTS

	Conduct the Annual Evaluation/Program Evaluation (HBS)
	Review, update and approve Emergency Preparedness (See One Page Checklist)
	Arrange for preparation of Medicare Cost Report (HBS)
	Review, Update, and Approve changes to the RHC Policy and Procedure Manual.
	Conduct Preventive maintenance on all equipment.

Source: https://www.ohsu.edu/xd/outreach/oregon-rural-health/clinics/rhc-ta-resources/upload/CMS-30.pdf

Evaluation of Clinic Medical Records

Each quarter the Medical Director should review at least 15 charts which should include active and closed charts. A report should be submitted with the annual evaluation process that indicates that at least 50 charts per annum were reviewed. Here is some of the criteria to use during the evaluation of the clinic medical records.

Criteria Used in Evaluation of Clinic Records

1. Vital Signs measured and recorded
2. Problem list is completed
3. Allergies or lack thereof clearly noted
4. Chief complaint
5. History of illness completed
6. P.E. correlates with complaint
7. Results of diagnostic testing documented
8. Results of procedures documented
9. Medication list is complete
10. Treatment plan is documented
11. All entries signed and dated
12. Informed consent signed
13. Physician signature present
14. Patient education Provided

The Medical Director should review 50 charts per year and present the findings to the Annual Evaluation/Program Evaluation Committee. We recommend the Medical Director review 15 charts (14 active, 1 closed) each quarter and document using the following form or something similar.

PHYSICIAN SUPERVISION LOG

	CHART NUMBER	DATE OF SERVICE	TREATMENT ACCEPTABLE	RECOMMENDATON
1			Y N Y W/RECOM	
2			Y N Y W/RECOM	
3			Y N Y W/RECOM	
4			Y N Y W/RECOM	
5			Y N Y W/RECOM	
6			Y N Y W/RECOM	
7			Y N Y W/RECOM	
8			Y N Y W/RECOM	
9			Y N Y W/RECOM	
10			Y N Y W/RECOM	
11			Y N Y W/RECOM	
12			Y N Y W/RECOM	
13			Y N Y W/RECOM	
14			Y N Y W/RECOM	
15			Y N Y W/RECOM	

PHYSICIAN SIGNATURE _____

CRNP SIGNATURE _____

DATE OF REVIEW _____

Some clinics use this form to document the quarterly Evaluation of medical records. Any form that is similar should be acceptable to the surveyor.

PATIENT RECORD QUALITY MANAGEMENT
CHECK LIST

DATE: _____ PROVIDER: _____

FACILITY: _____ OTHER: _____

PATIENT NAME	DATE OF VISIT	SOCIAL INFO	CURRENT RX?	ALLERGIES NOTED?	IMMUNS REC?	P.E./OBJ FINDINGS	DX IMP	DX TESTS	RX	PT INST GIVEN	ED GIVEN	F/U VISIT
TOTAL AVERAGE GRADE Check=standard met 0= standard not met N/A= not applicable												

COMMENTS: (OVERALL GRADE _____%)_____

Reviewer Sig_____Reviewed by Provider_____

*After review, this form is to be forwarded to the clinic manager for review and retention

Emergency Procedure and Emergency Kit Policy for Rural Health Clinic

The clinic provides medical emergency procedures as a first response to common life-threatening injuries and acute illness and has available the drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids.

In the event of an emergency, 911 will be called immediately and Basic Life Support will be administered until the Ambulance arrives. All clinical staff will be BLS certified. An AED will be available in the clinic if needed.

The Medical Director of the RHC reviewed the required medication categories as suggested in the RHC regulations to respond to medical emergencies and based upon the clinic's proximity to emergency services, clinical competency of the providers and staff, and local conditions and expected emergency situations the clinic does have in an emergency kit with the following medications available to treat minor emergencies:

1. analgesics,
2. anesthetics (local),
3. antibiotics,
4. anticonvulsants,
5. antidotes
6. emetics,
7. serums
8. toxoids.

This policy has been reviewed by the Medical Director and signed effective with the signature date:

_____

Signature

_____

Date

Provider Schedules. Keep a schedule for Nurse Practitioners/Pas for two months before the expected inspection date. The clinic must have a nurse practitioner or Physician Assistant for 50% of the time the clinic is open and the clinic must be providing at least 51% of the visits in primary care

Each date must include:
- **Clinic start time**
- **Clinic close time**

Number of Clinic Personnel: _____
Current Monthly Case Load for Covered Services: _____
Date of Last Medicare Patient: _____

Facility ID: _____ Month: _____ Hours of Availability

Sun	Mon	Tues	Wed	Thu	Fri	Sat

Clinic Director/Administrator must be present on all available dates listed above. If your availability changes, be sure to contact our office immediately. A cancellation fee may be incurred if surveyors have made travel arrangements and failure to notify AAAASF of such changes is not done prior to the cost assessed.

Patient Safety Compliance Checklist
To be completed by – Medical Assistant
Year: _____

Month	Expired Drug Samples	Sample Doors Locked	Emergency Drugs	Patient Exam Rooms	Locked Vaccine Room	Multiuse Vials Dated
January						
February						
March						
April						
May						
June						
July						
August						
September						
October						
November						
December						

Instructions

1. The Medical Assistants will review all drug samples, injectibles, medical supplies and biologicals on the last day of the month. By the last day of the month the Medical Assistant will inspect all samples, vaccines, emergency drugs, patient exam room supplies and dispose of any outdated supplies or medications that expire during the upcoming month. (ie. All drugs with a February expiration date will be discarded by January 31)

2. All doors of the Sample Room and VFC Room will remain locked at all times.
3. All opened multiuse vials will be dated and initialed and discarded within 28 days of opening.
4. Please clean the supply cabinets, and remove all clutter from the clinic. The clinic should be completely dust free as well at the end of the month.
Please initial in each of the boxes that you completed the task for the appropriate month.

5. The Nurse Practitioner will oversee this process on a quarterly basis to ensure it has been completed:

_____ 1st Quarter _____ 2nd Quarter _____ 3rd Quarter _____ 4th Quarter

Use the following form to conduct random walk throughs of the clinic to determine if the RHC is staying in compliance with RHC conditions of participation.

Date of review:
Reviewed by :

Exam Rooms and Procedure Rooms

1. room logs being utilized?
2. expired meds/supplies?
3. plug protectors?
4. closed trash containers?
5. holes or spots in walls that need repair?
6. locks on cabinets as necessary?
7. anything under sinks?
8. vials ointments and solutions dated appropriately?
9. any single use items opened and not discarded?
10. cleaning products secured?
11. drawers and cabinets neatly organized?
12. sharps containers mounted and dated appropriately?
13. splash guards present?

Patient Bathrooms

14. emergency notice in bathroom? System tested?
16. any chemicals or air freshener cans in bathrooms?
17. restroom labeled correctly?
18. holes or spots in walls that need repair?
19. plug protectors?

lab area

20. controls being done and logged as appropriate?
21. Is equipment clean?
22. splash guards present?
23. clean and dirty clearly defined?
24. nothing dirty in the clean area
25. holes or spots in walls that need repair?
26. UA testing capability?
27. Pregnancy testing capability?
28. Hemoccult testing capability?
29. Hemoglobin OR hematocrit capability?
30. Primary culturing capability? (flu swab, strep screen)

Medication/nurse area

31. signage on fridge - do not unplug, meds only..etc.
32. power outage procedure on door of imms
33. anything stored in doors of fridges?
34. schedule II drugs are double locked and logged separately?
35. allergy meds monitored separately for expiration?
36. oxygen tanks secured
37. oxygen tanks labeled in use and empty? Cannula ready?
38. emergency drug box easily accessible?
39. sample meds logged?
40. eye wash station checked and logged?
41. spill kit?
42. any safety concerns?
43. any auto clave process concerns?

waiting room and hallways

44. holes or spots in walls that need repair?
45. plug protectors?
46. clean?
47. Any safety concerns?
48. lock on cleaning supply closet
49. exit signs can be clearly seen and lights functioning?
50. Secondary doors are locked?
51. fire extinguishers are being checked monthly?
52. hallways are clean and unobstructed?

Check in area

53. HIPAA review/PHI
54. area neat and organized?

Signage and parking lot

55. hours of operation posted are correct?

signage review
any safety concerns?

Miscellaneous

APP hours meeting the 50% rule

OSHA® Occupational Safety and Health Administration
www.osha.gov

Here are the regulations and steps to comply with OSHA requirements for healthcare:

https://www.osha.gov/dcsp/compliance_assistance/quickstarts/health_care/index.html#step1

Healthstream is the source that a lot of healthcare providers use for OSHA annual training.

https://www.healthstream.com/solution/learning-compliance/compliance-learning

You may want the University of Alabama to come out. They have a free program that you can use.

https://alabamasafestate.ua.edu/safety-consultation/consultation_visit.php

AED Defibrillator Checklist
Fiscal Year: _____

The AED should undergo monthly checks by a responsible person. Different models of defibrillator may require different checks, however the principles are the same.

Here's our recommended monthly check list for an AED:

1. Visual check of device – check for any obvious damage or missing parts
2. Battery check – different models have different methods of warning about low battery.
3. Check defibrillator pads are sealed and in-date
4. Check spare defibrillator pads are sealed and in-date
5. Check accessory equipment is present: towel, razor, CPR face shield, scissors, gloves, paperwork
6. Check integrity and security of defibrillator cabinet

Month	Visual Check	Battery Check	Pads Sealed	Spare Pads	Accessories	Security
January						
February						
March						
April						
May						
June						
July						
August						
September						
October						
November						
December						

RHC Policy and Procedure
Expired Drugs Disposal
Year: _____

Once a month drug sample rooms will be examined for expired drugs and any expired drugs will be disposed of in accordance with State law for that drug.

Month	Expired Samples Disposed	Performed by:	Comments
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			

RHC Policy and Procedure
Emergency Drugs Expired Drugs Disposal
Year: _____

Once a month the crash cart will be examined for expired drugs and any expired drugs will be disposed of in accordance with State law for that drug.

Month	Expired Crash Cart Drugs Disposed	Performed by:	Comments
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			

Clinical Manager – Controlled Substances should be inventoried and reconciled daily. Use a forms similar to the following.

Controlled Substance Usage Log

Inspector: _____ License No. _____ Exp. Date: _____

Company: _____ Address: _____

Date	Drug	Form/Strength	Amount (Units)			Balance (Units)	Location
			Received	Used	Transferred		

www.FreePrintableMedicalForms.com

Daily – Record the Temperatures of Refrigerators (twice daily if VFC)

Temperature Log for Refrigerator and Freezer — Fahrenheit

Month/Year:_____ **Days 1–15**

Completing this temperature log: Check the temperatures in both the freezer and the refrigerator compartments of your vaccine storage units at least twice each working day. Place an "X" in the box that corresponds with the temperature and record the ambient (room) temperature, the time of the temperature readings, and your initials. Once the month has ended, save each month's completed form for 3 years, unless state or local jurisdictions require a longer time period.

If the recorded temperature is in the shaded zone: This represents an unacceptable temperature range. Follow these steps:

1. **Store the vaccine** under proper conditions as quickly as possible.
2. **Temporarily mark exposed vaccine "do not use"** until you have verified whether or not the vaccine may be used.
3. **Call the immunization program** at your state or local health department and/or the vaccine manufacturer to determine whether the vaccine is still usable: (_____) _____.
4. **Document the action taken** on the reverse side of this log.

Day of Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Staff Initials															
Room Temp.															
Exact Time															
°F Temp	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm
Too warm — ≥49°															
48°			Take immediate corrective action if temperature is in shaded section*												
Refrigerator temperature — 47°															
46°															
45°															
44°															
43°															
42°															
41°															
m for 40° — 40°															
39°															
38°															
37°															
36°															
35°															
Too cold — 34°															
33°			Take immediate corrective action if temperature is in shaded section*												
≤32°															
Too warm — ≥8°															
Freezer temp — 7°			Take immediate corrective action if temperature is in shaded section*												
6°															
5°															
4°															
≤3°†															

†Some frozen vaccines must not be stored colder than -58°F. Check the Prescribing Information on the vaccine manufacturer's website for specific storage temperature instructions.

Adapted by the Immunization Action Coalition courtesy of the Michigan Department of Community Health and the California Department of Health Services.

Technical content reviewed by the Centers for Disease Control and Prevention. August 2011.

www.immunize.org/catg.d/p3039f.pdf • Item #P3039F (8/11)

Distributed by the Immunization Action Coalition • (651) 647-9009 • www.immunize.org • www.vaccineinformation.org • admin@immunize.org

Source for forms: http://www.immunize.org/catg.d/p3037f.pdf

Record samples provided to patients in case of a drug recall. Record patient name, medication, lot number, etc.

SAMPLE MEDICATION LOG

DATE	PATIENT NAME	MEDICATION	LOT NO.	DOSE	# of SAMPLES GIVEN	EXP. DATE	SIGNATURE

Contract with a Biomedical Company to calibrate all medical/patient equipment annually and keep a log of this activity.

Equipment Name	Location	Standard	Condition	Action

Monthly ensure that maintenance on the building is in good order and document.

MONTHLY MAINTENANCE

Year _____

MONTH	SMOKE ALARMS	MEDICAL & LAB EQUIP	AIR HANDLING	PEST EXTERMIN	LIGHTING	SIGNAGE	REVIEWED BY
January							
February							
March							
April							
May							
June							
July							
August							
September							
October							
November							
December							

INSTRUCTIONS: The individual performing the maintenance should place his/her initial in the appropriate area. The office manager is to initial the last column to indicate he/she has reviewed the maintenance activity.

Daily and between each patient ensure the cleanliness and engage in infection control activities and log compliance.

CUSTODIAL SERVICES

Month: _____ Location: _____

Day	Disinfect Bathroom	Mop All Bathrooms	Mop Lab	Vacuum	Empty Trash	Dust	Clean Glass
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
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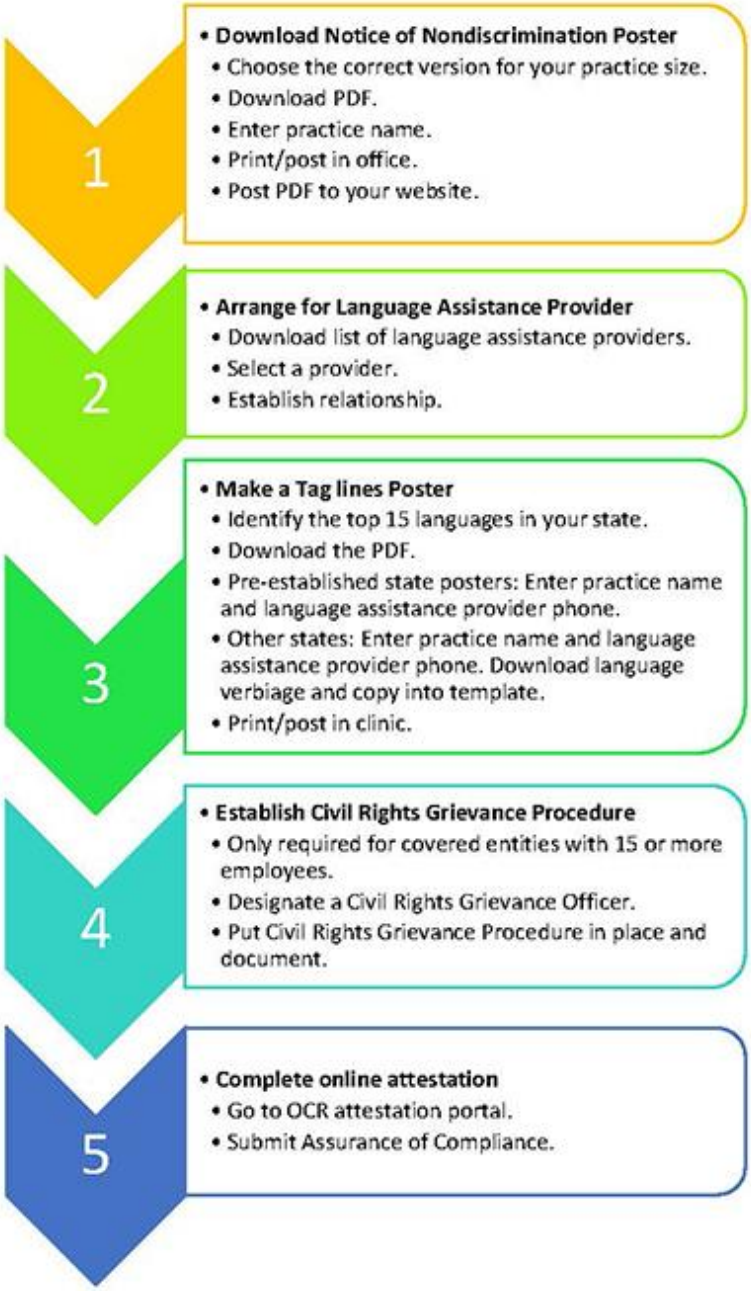
27							
28							
29							
30							
31							

ACA SECTION 1557 - ARE YOU IN COMPLIANCE?

Any practice that receives government funding (ie. Medicare Parts A, C & D [NOT B], Medicaid, Meaningful Use, etc.), you are REQUIRED to post information to be in compliance with Section 1557 of the Affordable Care Act (ACA) by Sunday, Oct. 16. All practices - regardless of practice size - are required to post the non-discrimination poster and the taglines poster, at minimum. Please read below for additional specifications regarding practices with 15 or more employees.

Section 1557 of the ACA contains an anti-discrimination provision. You may not discriminate in healthcare delivery based on a patient's race, color, national origin, sec, age or disability. You cannot delay or deny effective language assistant services to patient with limited English proficiency (LEP). These provisions apply to all patients in the US, legally or illegally. If your practice accepts payment from any HHS program or activity or an entity that HHS funds or you accept any Marketplace plans, this applies to YOU. Medicare Parts A, C & D (not Part B!), Medicaid, Meaningful Use, etc) Patients can sue for NON-COMPLIANCE of this ruling. For complete 1557 Compliance resources go to http://www.aoanow.org/?page=1557



Make sure you have this for all Employees

Health Care Professionals Hepatitis B Declination Statement

Hepatitis B Declination Statement*

The following statement of declination of hepatitis B vaccination must be signed by an employee who chooses **not to accept** the vaccine. The statement can only be signed by the employee following appropriate training regarding hepatitis B, hepatitis B vaccination, the efficacy, safety, method of administration, and benefits of vaccination, and that the vaccine and vaccination are provided free of charge to the employee. The statement is not a waiver; employees can request and receive the hepatitis B vaccination at a later date if they remain occupationally at risk for hepatitis B.

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on Statement

nd that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of ac
virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge
I decline hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk
hepatitis B, a serious disease. If, in the future I continue to have occupational exposure to blood or other potent
materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge

Signature:_____ Date:_____

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*Taken from: *Bloodborne Pathogens and Acute Care Facilities*. OSHA Publication 3128, (1992).

Makes sure Consent to Treat Forms are all signed within one year. The Inspectors will review 20 charts to ensure compliance.

Name of RHC

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Printed Name of Patient or Personal Representative **Relationship to Patient**

Emergency Preparedness

The **Centers for Medicare & Medicaid Services** (CMS) requires **Rural Health Clinics** to be in compliance with **all components** of the Emergency Preparedness final rule: **42 CFR Part 491.12**. These components **include but are not limited to** the following:

Risk assessment and emergency planning: An "all-hazards" risk assessment was performed, and essential components of this assessment have been integrated into the emergency preparedness plan and planning.

*1.*_____ **Date the most recent "all hazards" assessment was performed or updated.**

*2.*_____**Date the most recent review (revision, if applicable) of the emergency plan.**

Policies and Procedures: The facility has developed Policies and Procedures to promote and support the successful outcome of the emergency plan.

*3.*_____**Date the most recent review (revision, if applicable) of the Emergency Policies and Procedures.**

Communication Plan: The facility has developed and maintains a comprehensive emergency preparedness communication plan. The communication plan is fully coordinated within the facility, with state and local emergency management agencies, and with other healthcare providers as necessary.

4._____**Date the most recent review (revision, if applicable) of the Communication Plan.**

Training and Testing: The facility developed and maintains a training and testing program for emergency preparedness. The program includes initial training of staff and involves personnel as well as refresher courses, drills and exercises. The program includes methods to identify areas of the plan that need improvement and the processes and procedures to enact those improvements. *Dates within this section may only be used once and must be within the previous 12 calendar months. To be considered compliant, providers must submit two test dates* ***or*** *one test date along with a date the facility emergency plan was activated.*

5. **_____** ***and*** **_____ Dates of the most recent tests.**

6. _____ Date of the most recent training of staff on Emergency Preparedness

Contact with Local EMA Official regarding of Emergency Preparedness: The facility is knowledgeable of how to contact the local EMA Director and has consulted with them regarding the content of their emergency preparedness plans.

7. _____ Date of the most recent contact with local EMA Director.

For Resources to complete the Emergency Preparedness Process contact Mark Lynn at marklynnrhc@gmail.com or go to http://www.ruralhealthclinic.com/emergency-preparedness.