HEALTHCARE BUSINESS SPECIALISTS

RURAL HEALTH CLINIC ANNUAL EVALUATION

DATE

CLINIC NAME
CITY, STATE

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INTRODUCTION TO THE ANNUAL EVALUATION

GOALS AND OBJECTIVES

The goals and objectives of the annual evaluation process are to fulfill the obligation outlined in the Current Federal Register (42 CFR 491.11) and (Appendix G) Interpretative Guidelines of rural health clinic regulations related to program evaluation. The purpose of the evaluation is to determine whether:

1. the utilization of services was appropriate;
2. the established policies were followed; and
3. any changes are needed.

The regulations related to Program evaluation are outlined in Condition VIII of the Interpretative guidelines as follows:

An evaluation of a clinic's total operation including the overall organization, administration, policies and procedures covering personnel, fiscal and patient care areas must be done at least annually. This evaluation may be done by the clinic, the group of professional personnel required under 42 CFR 491.9(b)(2), or through arrangement with other appropriate professionals. The surveyor clarifies for the clinic that the State survey does not constitute any part of this program evaluation.

The total evaluation does not have to be done all at once or by the same individuals. It is acceptable to do parts of it throughout the year, and it is not necessary to have all parts of the evaluation done by the same personnel. However, if the evaluation is not done all at once, no more than a year should elapse between evaluating the same parts. For example, a clinic may have its organization, administration, and personnel and fiscal policies evaluated by a health care administrator(s) at the end of each fiscal year; and its utilization of clinic services, clinic records, and health care policies evaluated 6 months later by a group of health care professionals.

If the facility has been in operation for at least a year at the time of the initial survey and has not had an evaluation of its total program, report this as a deficiency. It is incorrect to consider this requirement as not applicable (N/A) in this case.

A facility operating less than a year or in the start-up phase may not have done a program evaluation. However, the clinic should have a written plan that specifies who is to do the evaluation, when and how it is to be done, and what will be covered in the evaluation. What will be covered should be consistent with the requirements of 42 CFR 491.11. Record this information under the explanatory statements on the SRF.

Review dated reports of recent program evaluations to verify that such items are included in these evaluations. When corrective action has been recommended to the clinic, verify that such action has been taken or that there is sufficient evidence indicating the clinic has initiated corrective action.

This annual evaluation report is prepared to evaluate the services and the effectiveness of the rural health clinic program offered by NAME OF CLINIC in CITY, STATE. In particular, the CFR cites the following regulations which this annual evaluation process fulfills:

Code J77 - The clinic carries out, or arranges for, an annual evaluation of its total program.

Code I78 - The evaluation includes review of:

1. the utilization of clinic services, including at least the number of patients served and the volume of services;

2. a representative sample of both active and closed clinical records; and

3. the clinic's health care policies.

Code J86 - The clinic staff considers the findings of the evaluation and takes corrective action if necessary.

Additionally, the interpretive guidelines stipulate that the group of professional personnel, which can be the governing body acting as the group, is responsible for an annual review of patient care policies. This report and process which is prepared by personnel not employed by the clinic is the product of the annual evaluation process.

The interpretive guidelines for rural health clinics further clarify what is required in an annual evaluation. [Section VIII - PROGRAM EVALUATION (42 CFR 481.11)] An evaluation of a clinic's total operation including the overall organization, administration, and policies and procedures covering personnel, fiscal and patient

care areas is to be done at least annually. This evaluation may be done by the clinic, the group of professional personnel required under section 481.9(b) (2), or through arrangements with other appropriate professionals.

The interpretive guidelines stipulate that the group of professional personnel, which can be the governing body acting as the group, is responsible for an annual review of patient care policies.

In consideration of the above regulations an annual evaluation committee was formed to evaluate the total rural health clinic program. This report reflects the minutes of the annual evaluation committee which met on DATE at TIME at the site of NAME OF CLINIC in CITY, STATE. The following are members of the annual evaluation committee for the clinic:

Name	Title	Date	Signature
	Medical Director		
	Physician Assistant		
	Office Manager		
	Community Member		

UTILIZATION AND SERVICES

The primary services of the rural health clinic are physician and nurse practitioner services provided by the physician(s), physician assistant(s), and nurse practitioner(s) under the direction of the medical director. Typical services include the following:

1. Office visits of a diagnostic nature
2. Laboratory services
3. Other diagnostic testing

The volume of patients is as follows:

Description	FTEs	2015 Visits
Physician(s)		
Physician Assistant(s)		
Nurse Practitioner(s)		
Totals		

ACTIVE & CLOSED MEDICAL CHARTS

While on-site 15 medical charts were reviewed (10 open and 5 closed) for adequate documentation of services performed. The records were found to be in generally good order and SOAP notes were taken appropriately. The following charts at NAME OF CLINIC in CITY, STATE were reviewed during the annual evaluation process. All charts were found to be in good order and the results of laboratory work, radiology, and consultations were recorded accordingly.

The following is a table listing the 10 open or active charts that were reviewed onsite:

Active Chart Name	Active Chart Name
1	6
2	7
3	8
4	9
5	10

The five closed or inactive charts that were reviewed were as follows:

Inactive Chart Name	Inactive Chart Name
A	D
B	E
C	

The patient health records regulations (42 CFR 491.10) and interpretative guidelines as related to the patient records system. The clinic is to maintain patient health records in accordance with its written policies and procedures. These records are the responsibility of a designated member of the clinic's professional staff and should be maintained for each person receiving health care services. All records should be kept at the clinic site so that they are available when patients may need unscheduled medical care.
The clinic must protect medical records. The clinic must ensure the confidentiality of the patient's health records and provide safeguards against loss, destruction, or unauthorized use of record information. We ascertained that information regarding the use and removal of records from the clinic and the conditions for release of record information is in the clinic's written policies and procedures. The patient's written consent is necessary before any information not authorized by law may be

released. The clinic is following these procedures in compliance with RHC regulations.

The clinics retention of records policy reflects the necessity of retaining records at least 6 years from the last entry date or longer if required by State statute.

REVIEW OF POLICIES

The patient care polices requirements require that the clinic review the policies and ascertain who developed them. Where changes in clinic personnel and/or clinic administration make it impossible or not relevant to ascertain who developed the policies, it is necessary to ascertain that the current physician member(s) and the nurse practitioner, certified nurse-midwife, and/or physician assistant member(s) of the staff have an in-depth knowledge of the policies and have had the opportunity to discuss them, adopt them as is, or make any agreed- to written changes in them. If a clinic's organizational structure includes a governing body, ascertain whether the governing body has ultimate authority in approving the patient care policies and, if so, when such approval was last given. While clinics frequently seek the participation of other health care professionals in developing patient care policies (particularly the written guidelines for the medical management of health problems) the term "a group of professional personnel" is not restricted to health care professionals. In some cases, the clinic will have involved health care professional's representatives to a hospital with which the clinic has an agreement for patient referral. In any event, one member of the group of three or more may not be a member of the clinic's staff, and professions which are not directly related to health care delivery (attorneys, community planners, etc.) are potentially useful.

The requirements concerning written policies address four areas:

Description of Services. – A description of the services the clinic furnishes directly and those furnished through agreement or arrangement. The services furnished by the clinic should be described in a manner than informs potential patients of the types of health care available at the clinic, as well as setting the parameters of the scope of what services are furnished through referral. Such statements as the following sufficiently describe services: Taking complete medical histories, performing complete physical examinations, assessments of health status, routine lab tests, diagnosis and treatment for common acute and chronic health problems and medical conditions, immunization programs, family planning, complete dental care, emergency medical care. Statements such as "complete management of common acute and chronic health problems" standing alone, do not sufficiently describe services.

Additional services, furnished through referral, are sufficiently described in such statements as: Arrangements have been made with X hospital for clinic patients to receive the following services if required: specialized diagnostic and laboratory testing, specialized therapy, inpatient hospital care, physician services, outpatient and

emergency care when clinic is not operating, referral for medical cause when clinic is operating.

Guidelines for Medical Management. – The clinic's written guidelines for the medical management of health problems include a description of the scope of medical acts which may be undertaken by the physician assistant, certified nurse-midwife, and/or nurse practitioner. They represent an agreement between the physician providing the clinic's medical direction and the clinic's physician assistant, certified nurse-midwife, and/or nurse practitioner on the privileges and limits of those acts of medical diagnosis and treatment which may be undertaken without direct, over the shoulder physician supervision. They describe the regimens to be followed and stipulate the conditions in the illness or health care management at which consultation or referral is required.

Acceptable guidelines may follow various formats. Some guidelines are collections of general protocols, arranged by presenting symptoms; some are statements of medical directives arranged by the various systems of the body (such as disorders of the gastrointestinal system); some are standing orders covering major categories such as health maintenance, chronic health problems, common acute self-limiting health problems, and medical emergencies.

The way these guidelines describe the criteria for diagnosing and treating health conditions may also vary. Some guidelines will incorporate clinical assessment systems that include branching logic. Others may be in a more narrative format with major sections covering specific medical conditions in which such topics as the following are discussed: The definition of the condition, its etiology, its clinical features, recommended laboratory studies, differential diagnosis, treatment procedures, complications, consultation/referral required, and follow-up.

Even though approaches to describing guidelines may vary, acceptable guidelines for the medical management of health problems must include the following essential elements. They:

Are comprehensive enough to cover most health problems that patients usually see a physician about;

Describe the medical procedures available to the nurse practitioner, certified nurse midwife, and/or physician assistant;

Describe the medical conditions, signs, or developments that require consultation or referral; and

Are compatible with applicable State laws.

Several patient care guidelines have been published by members of the medical profession. Should a clinic choose to adopt such guidelines (or adopt them essentially with noted modifications), this would be acceptable if the guidelines include the essential elements described above.

Drugs and Biologicals. – Written policies cover at least the following elements:

Requirements dealing with the storage of drugs and biologicals in original manufacturer's containers to assure that they maintain their proper labeling and packaging;

Requirements dealing with outdated, deteriorated, or adulterated drugs and biologicals being stored separately so that they are not mistakenly used in patient care prior to their disposal in compliance with applicable laws;

Requirements dealing with storage in a space that provides proper humidity, temperature, and light to maintain the quality of drugs and biologicals;

Requirements for a securely constructed locked compartment for storing drugs classified under Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1970;

Requirements dealing with the maintenance of adequate records of receipt and distribution of controlled drugs that account for all drugs in Schedules II, III, IV, and V; with Schedule II drugs being accounted for separately;

Requirements that containers used to dispense drugs and biologicals to patients conform to the Poison Prevention Packaging Act of 1970;

Requirements dealing with the complete and legible labeling of containers used to dispense drugs and biologicals to patients;

Requirements concerning the availability of current drug references and antidote information; and

Requirements dealing with prescribing and dispensing drugs in compliance with applicable State laws.

Review of Policies. – The group of professional personnel, which can be the governing body acting as the group, is responsible for an annual review of patient

care policies which is conducted as a part of this annual review and evaluation of the rural health clinic program.

The providers and staff were asked if they knew of any policies and procedures which were not working or needed changes and none were noted; however, we have recommended completely updating the Policy and Procedure Manuals and completed an overhaul of the policies and procedures and compliance communication. We implemented six new policies as listed:

1. Incident to Billing policy to incorporate changes in Chapter 13 of the Medicare Manual
2. Emergency medications onsite – Medical Director's approval
3. Consent to treat
4. OIG policies
5. Cleaning of patient exam rooms
6. Requirements for Employee files and personnel records.

DIRECT SERVICES

Rural Health Clinics are required to provide the following direct services. The purpose of the Rural Health Clinic Services Act is primarily to make available outpatient or ambulatory care of the nature typically provided in a physician's office or outpatient clinic and the like. The regulations specify the services which must be made available by the clinic, including specified types of diagnostic examination, laboratory services, and emergency treatments.

The clinic's laboratory is to be treated as a physician's office for the purpose of licensure and meeting health and safety standards. The listed laboratory services are considered essential for the immediate diagnosis and treatment of the patient. To the extent they can be provided under State and local law, the nine services listed in J61, HCFA-30, are considered the minimum the clinic should make available through use of its own resources.

If any of these laboratory services cannot be provided at the clinic under State or local law, that laboratory service is not required for certification.

Some clinics are not able to furnish the six services, even though they may be allowed to do so under State and local law, without involving an arrangement with a Medicare approved laboratory.

Those clinics unable to furnish all six services directly when allowed to by State and local law should be given deficiencies. Such deficiencies should not be considered sufficiently significant to warrant termination if the clinic has an agreement or arrangement with an approved laboratory to furnish the basic laboratory service it does not furnish directly, especially if the clinic is trying to meet this requirement.

Typical RHC Services

Laboratory Services:	Evaluations:
Blood glucose Hemoccult In-house CBC Pregnancy testing Quick mono Quick strep Urinalysis Wet prep	12 lead EKG Holter monitor (24 hours) Pulse oximetry Spirometry Temperature measurement X-rays
Examinations:	**Injections:**
Cervical &uterine cancer screening DOT physicals EPSDT physicals Geriatric care Men's health (including prostate exam) Pediatric/newborn care Women's health (excluding obstetrics) Work & school physicals	Allergy shots Flu vaccine Pneumonia vaccine Subcutaneous & intramuscular TB skin test Tetanus diphtheria toxoid
Procedures:	**Treatments:**
Foreign bodies in the ear In house minor surgeries Irrigating the external auditory canal Splinting Suturing (simple lacerations) Tick removal Venipunture Wound Care	Oxygen administration Nebulizer therapy

DEMOGRAPHICS

As of the census of 2010, there were 12,301 people, 4,600 households, and 2,848 families residing in the city. The population density was 1,064.1 inhabitants per square mile (410.9/km2). There were 5,217 housing units at an average density of 451.3 per square mile (174.2/km2). The racial makeup of the city was 85.7% White, 3.9% African American, 1.3% Native American, 3.9% Asian, 1.8% from other races, and 3.4% from two or more races. Hispanic or Latino of any race were 6.1% of the population.

There were 4,600 households of which 32.0% had children under the age of 18 living with them, 44.7% were married couples living together, 12.2% had a female householder with no husband present, 5.1% had a male householder with no wife present, and 38.1% were non-families. 32.5% of all households were made up of individuals and 13.8% had someone living alone who was 65 years of age or older. The average household size was 2.37 and the average family size was 2.98.

The median age in the city was 36.7 years. 23% of residents were under the age of 18; 12% were between the ages of 18 and 24; 25% were from 25 to 44; 24.4% were from 45 to 64; and 15.7% were 65 years of age or older. The gender makeup of the city was 50.7% male and 49.3% female.

CONCLUSION

The annual evaluation committee evaluated the services of NAME OF CLINIC in CITY, STATE and conducted the annual evaluation with the following goals:

1. to determine if the utilization of services was appropriate;
2. if the established policies were followed; and
3. any changes are needed.

The following procedures were completed to assist the evaluation committee in determining if the goals had been achieved:

Information on utilization of services was gathered

A sample of 15 charts were reviewed

Evaluations of the office manager and nurse practitioner

A review of the policies and procedures

A walk though of the clinic to determine any compliance issues

Based upon the number of patients served and the potential market share, the rural health clinic is being productive and is benefiting the health care of patients in CITY, STATE and surrounding areas. The Annual Evaluation Committee's conclusion is that NAME OF CLINIC in CITY, STATE is providing services appropriately and is following established policies.