MEDCARE COMMUNITY CLINIC

Medical Policies & Procedures Manual

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HIPAA COMPLIANCE & PATIENT PRIVACY

1.1 Protected Health Information (PHI) Handling

Definition of PHI: Protected Health Information includes any individually identifiable health information transmitted or maintained in any form (electronic, paper, oral) that relates to:

- Past, present, or future physical or mental health condition
- Provision of healthcare to an individual
- Payment for healthcare services

Access Controls:

- All staff must complete HIPAA training within 30 days of employment
- PHI access limited to minimum necessary for job function
- Workstations must be positioned away from public view
- Computer screens locked when unattended (maximum 5 minutes)
- Clean desk policy enforced in all patient care areas

Minimum Necessary Standard: Staff may only access, use, or disclose the minimum amount of PHI necessary to accomplish the intended purpose. Examples:

- **Scheduling staff:** Patient name, contact info, appointment type - NOT medical history
- **Billing staff:** Insurance info, diagnosis codes, procedures - NOT detailed clinical notes
- **Nurses:** Full medical record access for assigned patients only
- **Providers:** Full access for patients under their care

1.2 Patient Consent and Authorization

Standard Consent Procedures:

1. **General Consent:** Obtained at first visit for routine care, payment, and healthcare operations
2. **Specific Authorization:** Required for:
    - Sharing information with family members
    - Psychotherapy notes disclosure
    - Marketing communications
    - Research participation
    - Third-party requests (legal, insurance beyond claims)

Documentation Requirements:

- All consent forms signed and dated by patient
- Witness signature required for patients unable to sign
- Electronic signatures acceptable with audit trail
- Consent forms retained for 6 years minimum

1.3 Breach Notification Procedures

Immediate Response (within 1 hour):

1. Secure the breach area and prevent further disclosure
2. Notify HIPAA Security Officer: hipaa@medcare-clinic.com
3. Document incident details, affected individuals, and timeline
4. Do NOT discuss breach with unauthorized personnel

Investigation Timeline:

- **0-24 hours:** Initial assessment and containment
- **24-72 hours:** Full investigation and risk assessment
- **Within 60 days:** Patient notification if required
- **Within 60 days:** HHS notification via OCR portal

Risk Assessment Factors:

- Nature and extent of PHI involved
- Unauthorized person who received PHI
- Whether PHI was actually acquired or viewed
- Extent to which risk has been mitigated

PATIENT CARE PROTOCOLS

2.1 Patient Check-in and Registration

New Patient Process:

1. **Welcome and Forms (10 minutes):**
    - Photo identification verification
    - Insurance card copying (front and back)
    - Complete medical history questionnaire
    - Current medication list with dosages
    - Emergency contact information
2. **Clinical Review (5 minutes):**
    - Nurse reviews completed forms
    - Vital signs collection (height, weight, blood pressure, temperature)
    - Chief complaint documentation
    - Allergy verification and documentation
3. **Provider Preparation:**
    - Electronic health record (EHR) updated with new information
    - Previous records requested if applicable
    - Provider notified of patient readiness

Established Patient Process:

1. **Insurance Verification:** Check current coverage and copay requirements
2. **Update Review:** Confirm address, phone, emergency contacts, medications

3. **Vital Signs:** Standard vitals unless provider specifies otherwise
4. **Wait Time Management:** Notify patients if delays exceed 20 minutes

2.2 Clinical Assessment Standards

Documentation Requirements (SOAP Format):

- **Subjective:** Patient's description of symptoms, concerns, history
- **Objective:** Physical examination findings, vital signs, test results
- **Assessment:** Clinical impression, differential diagnosis
- **Plan:** Treatment plan, medications, follow-up instructions

Time Standards:

- **Routine Visit:** 15-20 minutes with provider
- **Annual Physical:** 30-45 minutes with provider
- **Acute Illness:** 10-15 minutes with provider
- **Follow-up Visit:** 10-15 minutes with provider

Red Flag Symptoms Requiring Immediate Escalation:

- Chest pain with cardiac risk factors
- Difficulty breathing or shortness of breath
- Severe headache with neurological symptoms
- High fever (>103°F) with altered mental status
- Severe abdominal pain
- Signs of stroke (FAST protocol)

2.3 Prescription and Medication Management

Electronic Prescribing Requirements:

- All prescriptions sent electronically unless technical failure
- Controlled substances require additional verification
- Drug interaction checking enabled for all prescriptions
- Allergy alerts must be acknowledged before prescribing

Controlled Substance Protocols:

- DEA number verification for all prescribing providers
- Patient identification required for all controlled substance prescriptions
- No telephone prescriptions for controlled substances
- Maximum 30-day supply for new patients
- Prescription drug monitoring program (PDMP) check required

Medication Reconciliation:

- Complete at every visit
- Include prescription medications, over-the-counter drugs, supplements
- Document medication changes, discontinuations, and new prescriptions
- Patient education provided for all new medications

MEDICAL RECORDS MANAGEMENT

3.1 Electronic Health Record (EHR) Standards

Documentation Timeliness:

- Progress notes completed within 24 hours of patient encounter

- Diagnostic test results reviewed and documented within 48 hours
- Consultation reports filed within 72 hours of receipt
- Hospital discharge summaries reviewed within 5 business days

Record Retention Requirements:

- **Adult Records:** Retained for 10 years after last patient contact
- **Pediatric Records:** Retained until age 21 or 10 years after last contact, whichever is longer
- **Deceased Patients:** Records retained for 5 years after date of death
- **Sensitive Records:** Mental health and substance abuse records retained per state requirements

Access Audit Procedures:

- All EHR access logged automatically
- Monthly audit reports generated for unusual access patterns
- Quarterly review of terminated employee access
- Annual comprehensive access review for all active users

3.2 Paper Records Management

Physical Security Requirements:

- Medical records stored in locked file cabinets
- Records room access restricted to authorized personnel
- Keys issued only to designated staff with access log
- Security cameras monitor records storage areas

Filing and Organization:

- Alphabetical filing system with color-coded year tabs
- Active records (last 2 years) in primary filing area
- Inactive records moved to secure off-site storage
- Purge schedule followed according to retention requirements

3.3 Release of Information

Standard Procedures:

1. **Written Authorization Required** for all non-routine disclosures
2. **Identity Verification** of requesting party
3. **Fee Schedule** applied for copying (medical records specialist)
4. **Processing Timeline:** 15 business days maximum

Fees (2025 Schedule):

- First 10 pages: $15.00
- Pages 11-50: $0.75 per page
- Pages 51+: $0.50 per page
- Electronic records: $10.00 setup fee + per-page rates
- Rush processing (48 hours): Additional $25.00

INFECTION CONTROL PROCEDURES

4.1 Hand Hygiene Standards

WHO 5 Moments for Hand Hygiene:

1. Before touching a patient

2. Before clean/aseptic procedures
3. After body fluid exposure risk
4. After touching a patient
5. After touching patient surroundings

Technique Requirements:

- **Alcohol-based hand rub:** Minimum 15 seconds coverage
- **Soap and water:** Minimum 20 seconds with friction
- **Surgical scrub:** 3-5 minutes for sterile procedures
- Hand hygiene compliance monitored quarterly with >90% target

4.2 Personal Protective Equipment (PPE)

Standard Precautions (All Patients):

- Gloves for any potential contact with blood, body fluids, mucous membranes
- Eye protection when splashing is possible
- Masks for respiratory protection during aerosol-generating procedures
- Gowns when clothing may become contaminated

Transmission-Based Precautions:

- **Contact Precautions:** Gown and gloves for resistant organisms
- **Droplet Precautions:** Surgical mask within 3 feet of patient
- **Airborne Precautions:** N95 respirator in negative pressure room

4.3 Environmental Cleaning and Disinfection

Daily Cleaning Requirements:

- All patient care surfaces cleaned between patients
- High-touch surfaces (door handles, light switches) cleaned every 2 hours
- Examination tables disinfected after each patient
- Blood pressure cuffs cleaned after each patient use

Terminal Cleaning (End of Day):

- All patient care areas mopped with approved disinfectant
- Trash removed and replaced
- Equipment cleaned and stored appropriately
- UV-C disinfection in high-risk areas when available

Approved Disinfectants:

- EPA-registered hospital-grade disinfectants
- Minimum contact time per manufacturer instructions
- Material Safety Data Sheets (MSDS) available for all chemicals
- Staff training required for chemical handling

PRESCRIPTION MANAGEMENT

5.1 Prescribing Authority and Protocols

Authorized Prescribers:

- **Physicians (MD/DO):** Full prescribing authority including controlled substances
- **Nurse Practitioners:** Prescribing per state scope of practice and collaborative agreements

- **Physician Assistants:** Prescribing under physician supervision per state requirements

Prescription Review Process:

1. **Clinical Indication:** Documented diagnosis supporting medication choice
2. **Drug Interactions:** Electronic checking system alerts reviewed
3. **Allergy Verification:** Patient allergy list checked before prescribing
4. **Dosing Appropriateness:** Age, weight, renal function considered
5. **Insurance Formulary:** Preferred medications selected when clinically appropriate

5.2 Controlled Substance Management

DEA Requirements Compliance:

- All controlled substance prescriptions tracked in secure system
- Inventory counts performed monthly for on-site medications
- Prescription pads secured in locked drawer/cabinet
- Voided prescriptions retained and documented

Red Flag Monitoring:

- Early refill requests (>3 days early without clinical justification)
- Multiple providers for same medication class
- Cash payments for controlled substances when insurance available
- Excessive lost or stolen prescription reports
- Requests for specific medications or dosages

5.3 Medication Sample Management

Sample Storage Requirements:

- Temperature-controlled storage (36-77°F)
- Expiration date monitoring with monthly checks
- Lot number tracking for recall purposes
- Locked storage for controlled substance samples

Distribution Protocols:

- Provider authorization required for all samples
- Patient counseling provided on sample medications
- Follow-up plan established for continued therapy
- Documentation in patient record including lot number and expiration

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LABORATORY AND DIAGNOSTIC PROCEDURES

6.1 Point-of-Care Testing (POCT)

Approved Tests:

- Rapid strep test (throat culture backup if negative)
- Urine pregnancy test
- Urine dipstick analysis
- Blood glucose monitoring
- Hemoglobin A1C testing
- INR/PT monitoring for anticoagulation

Quality Control Requirements:

- Daily controls run on all POCT devices
- Monthly competency assessment for staff performing tests
- Annual proficiency testing participation
- Equipment maintenance per manufacturer specifications

6.2 Laboratory Specimen Collection

Collection Standards:

- **Phlebotomy:** Certified medical assistant or nurse
- **Patient Identification:** Two patient identifiers verified
- **Chain of Custody:** Maintained for legal specimens
- **Specimen Labeling:** At bedside after collection
- **Transport Requirements:** Temperature and time specifications followed

Critical Values Management:

1. **Laboratory contacts clinic immediately** for critical results
2. **Provider notified within 30 minutes** during business hours
3. **Patient contacted within 2 hours** with follow-up plan
4. **Documentation required** of notification and patient response

6.3 Diagnostic Imaging Coordination

Referral Requirements:

- Clinical indication documented in referral
- Prior authorization obtained when required
- Patient preparation instructions provided

- Insurance verification completed before scheduling

Results Management:

- **Routine Results:** Reviewed within 48 hours
- **Abnormal Results:** Reviewed within 24 hours with patient notification
- **Critical Results:** Immediate review with urgent patient contact
- **Documentation:** All result reviews documented in patient record

Patient Communication:

- Results discussion scheduled with provider when abnormal
- Written results summary provided to patient
- Follow-up recommendations clearly documented
- Patient portal notification for routine normal results

Document Control:

- **Effective Date:** January 15, 2025
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- **Approved By:** Dr. Sarah Mitchell, Medical Director
- **Document Owner:** Quality Assurance Committee

For questions regarding these policies, contact:

- **Medical Director:** ssmith@medcare-clinic.com
- **Quality Assurance:** qa@medcare-clinic.com
- **HIPAA Security Officer:** hipaa@medcare-clinic.com
