SAMPSON COUNTY HEALTH DEPARTMENT

Wanda Robinson
Health Director

360 County Complex Road, Suite 200
Clinton NC 28328

Sampson County Health Department Advisory Committee

Meeting Agenda

August 20, 2018 7:00 pm

I. Call to Order – Jacqueline Howard, Chair

II. Invocation

III. *Approval of minutes

a. June 18, 2018 minutes

IV. Policy review

a. HIPAA Policy
b. Administrative Policy

V. Financial Report

VI. Dangerous Dog Ordinance Review- Joel Starling, County Attorney

VII. Health Directors Report

a. Personnel Changes/vacancies
a. Child Fatality 2017 Annual Report
b. Child Fatality Committee Appointment
c. Accreditation Update

VIII. Public Comment

IX. Adjournment

*Requires Board Approval

Sampson Count Health Department Advisory Committee Minutes
June 18, 2018

Member Attendance: Dr. Jeffrey Bell, Paul Bradshaw, Dr. Beth Bryan, Robert Butler, Charlotte Harrell, Linda Heath, Jacqueline Howard, Chair, Allie Ray McCullen and Commissioner Harry Parker.

SCHD staff attendance: Wanda Robinson, Tamra Jones, Annie Fennell, Perry Solice.

Administration staff attendance: Edwin Causey, Susan Holder

I. Call to Order:
Jacqueline Howard, Chair call the Advisory Committee meeting to order.

II. Invocation:

III. Approval of Minutes:

a. April 16, 2018 minutes - motion made by Linda Peterson to approve April 16, 2018 minutes as presented and second made by Charlotte Harrell. All in favor. Motion carried.
b. May 14, 2018 Dangerous Dog Hearing Appeal minutes: -motion made by Dr. Beth Bryan to approve minutes as presented and second made by Robert Butler. All in favor. Motion carried.

IV. Additions/Deletions to agenda:
No additions/deletions.

V. Clinic Report:
Wanda Robinson reported on changes with Communicable Diseases Orders. See attached handout. Reviewed points 1, 2 and 3. Discussed how the changes effects the way the Health Department does business with Isolation orders. Patient's will have to prove they are under care and are suppressed.

VI. EH Report:
Handouts: NC Food Code Manual-Prohibiting Animals; Frequently Asked Questions about Service Animals and the ADA.

Frequently Asked Questions about Service Animals and the ADA:
Perry Solice reviewed and discussed the above handout. Public does not understand definition of a service animal. Service animal must be trained to perform a specific action(s). Emotional support animals are not considered service animals. Anxiety attacks-service animals that have been trained to sense an anxiety attack is about to happen and take a specific action to avoid or lessen the attack would be considered as a service animal. Restaurants or food establishments are allowed to ask only certain questions regarding in determining if is a true service animal. Service animal must remain on the floor. Service animals are allowed to go through a salad bar or other self-service food line. Service animals do not have to wear vest or harness. Service animals do not have to be certified or registered, but must be vaccinated. Service animal may be any breed of dog.

NC. Food Code Manual-Prohibiting Animals:
Perry Solice reviewed and discussed above handout. This is the code that Environmental Health follows. Issue reported of local restaurant employee feeding a dog food from the drive thru window. Question was asked are biggest complaints of dogs in food places. Perry responded, "Yes." Comment made that Social Services has had issues with people bringing animals into department that were not service animals-animals were not permitted to stay within department.

Discussion from committee members. Situation with services dogs will get worse. It will be hard to determine if the animal is a service dog due to inability to require papers. Question was asked if anything going to restaurants about what the rules. May need to have restaurants post signs Service Animals Only. Request was made for Perry to do an article to define and explain about service dogs.
Commissioner Parker questioned, if there was anything else Perry-EH can do? Wanda's response, Person can be sighted if do is on the table or eating from plates. Perry's response, 911 can be called for a deputy to come and escort out of restaurant.

VII. <u>Dangerous Dog Ordinance Review:</u>

Handout: Animal Control Ordinance of Sampson County.
Wanda Robinson reviewed and discussed the above handout. The ordinance is the guiding principle. We may want to have the county attorney look at page 15, article 3. On page 16 – Dangerous/Potentially Dangerous. The dog did not bite anyone, but did run out. The differences are vague and hard to walk through. Potentially Dangerous finding is treated as Dangerous. Linda Heath – noted the differentiation was ambiguous. On page 18, Section 1-33 letter a: she does not see they should take a potentially dangerous dog from their owner. Robert Butler asked if the dog was not considered dangerous until deemed dangerous by the board. Wanda clarified the determination is made by animal control and only the contested ones come to the board. Dr. Bryan stated as a question – So the officer deems the animal dangerous? Mrs. Howard noted the verbiage of feeling fearful of a bite is too close to dangerous. Wanda clarified that is when the board has to listen to both sides and decide based on what is presented. Mr. Parker stated – Dogs growl and show their teeth. Different breeds do certain things. Mr. Butler asked when is it dangerous if they are doing what their breed does. Linda Heath questioned why owners could not be held more accountable. Page 20 needs input from Joel. Can we not deem dangerous, but require dog to be kept indoors, on a leash, etc. If the dog breaks the stipulations, then dog owner could be fined. Wanda said that is where we can get into trouble. Linda Heath went on to say, on page 23 – if the dog is taken to animal control, animal control should be responsible. The dog should not have gotten out. Dr. Bryan said, owners are not being responsible, dog should not be wandering. Susan Holder called attention to the fee schedule in the ordinance. On the last page, the board could ask them to enforce fees. Wand said, we never know the violations they are citing – she doesn't remember it being in the report. Mr. Parker said all we have to go by is the investigation. Wanda would like Susan Holder to ask Joel to give some guidance – after July, Joel will be attending all meetings per Susan Holder. Mr. Butler asked if there was a difference between dangerous and potentially dangerous. Do they get the same results in the end? Wanda said a bite is the difference. Dr. Bryan asked why it matters if they are dangerous or potentially dangerous if there is the same outcome. Susan said, it is language in the general statue. Wanda suggested to wait for more clarification from Joel. Board members mentioned it would be good to meet prior to

the next dangerous dog meeting to go over the rules. It was also suggested the animal control officer needs to be at meetings from now on. Mr. Causey asked that detailed questions be sent to Joel so he could look over them and prepare.

VIII. Financial Report:

Tamra Jones reviewed handouts of Activity Summary for FY 2017-2018; Medicaid Revenues; Medicaid Revenue chart; Local Revenues and Local Revenue chart, and EH Local Revenue chart.

IX. New Fee approval:

Request to add Shingrix (Zoster Vaccine) Code 90750 new fee $175.00 and Smear, Wet Mount Code 87210 fee $12.00. Discussion- Charlotte Harrell and Dr. Bryan stated that the Shingrix is the better of the two Zoster Vaccines. Once Shingrix is approved, we will be able to order and offer vaccine. Motion made by Paul Bradshaw to accept new Shingrix code and fee and add Smear, Wet Mount Code back to fee schedule.

X. Rural Health Grant Approval:

Awarded $150,000 grant for next 3 years. These funds will help fill the gaps and will be used for salaries, medical supplies and other things. We waiting on the paperwork hope to have by Board of Commissioner's meeting scheduled for July. Motion made by Dr. Elizabeth Bryan to accept the Rural Health Grant funds; seconded by Dr. Jeffery Bell. All in favor. Motion carried.

XI. Health Directors Report:

a. 2018 County Health Rankings
   Wanda reviewed pages 12 and 13 of the booklet handout for 2018 County Health Rankings. Sampson County out of 100 county ranks 79th in Health Outcomes and 82nd in Health Factors.
b. 2018 Child Health Report
   See handout attached. Wanda discussed 2018 NC Data Card. Sampson County is in the highest percent for Teen births. Children in Foster Care: 65% of children in foster care for Sampson County due to parent's substance abuse.
c. Opioid Conference:
   Opioid Conference is scheduled for September 12th 10 am to 2 pm at the Civic Center. Hoping for 500 people to attend. Sampson County has an opioid problem.

XII. Public Comment:

No Public Comment.

XIII. Adjournment:

Motion made by Robert Butler to adjourn meeting, seconded by Paul Bradshaw. All in favor. Motion carried.

Chairman Date Secretary Date

Sampson County Health Department

HIPAA PRIVACY

(Health Insurance Portability & Accountability Act)

POLICY & PROCEDURE MANUAL

Table of Contents

Sampson County Health Department
HIPAA Policy & Procedures Year: 2018

Manual: SCHD HIPAA Manual	Applicable Signatures/Title:
Title: SCHD HIPAA Policy & Procedures	Program Coordinator/Specialist: N/A
□ Program Policy: _____Program	Supervisor: N/A
□ Program Procedure: _____Program	Director of Nursing: N/A
X Management/Department-wide Policy	Medical Director: Dr. Allyn Dambeck
□ workforce Policy	Health Director: Wanda Robinson
□ Fiscal Policy	Board of Health Chair: Jacqueline Howard
Distributed to: All workforce	Effective Date: 04/01/18
	Supersedes: 04/01/2017

Purpose:

To provide guidance to all Sampson County Health Department (SCHD) workforce regarding the laws, rules and regulations as they relate to the privacy and confidentiality of the protected health information (PHI) for all health department patients.

Policy:

Sampson County Health Department recognizes the importance of all aspects of a patient's right to confidentiality and privacy as it relates to the medical information.
The HIPAA Privacy Rule provides that patients have a right to notice of how we may use and disclose a patient's PHI, as well as the patient's rights and the obligations regarding their PHI. We have developed a Notice of Privacy Practices to meet these requirements and will make the Notice available to the patients as described in this policy. Our Practice will strive to abide by the terms of the Notice as currently in effect.
The Sampson County Health Department (SCHD) will implement policies and procedures as required by and specified in the privacy rule of the Administrative Provision in the Health Insurance Portability and Accountability Act of 1996.

Definitions:

This Manual has a Glossary of Terms that explains terms used in the Manual – refer to the Appendix, Attachment A. Every staff person should review and consult the Glossary when reviewing or consulting this Policy Manual.

Applicable Laws, Rules and Regulations:

USC Public Law 104-191: Health Insurance Portability & Accountability Act (HIPAA) of 1996.
45 CFR, Part §160, General Administrative Requirements.
45 CFR, Part § 162, Administrative Requirements.
45 CFR, Part § 164, Security & Privacy.
North Carolina General Statute § 8-53.6.
North Carolina General Statute § 8-53.13.
North Carolina General Statute § 130A-12.
North Carolina General Statute § 130A-143-144.

Responsible Persons:

Sampson County Health Department workforce

Procedures:

1. This policy provides the guidelines for the handling of patient medical protected health information (PHI) as set forth by the federal Public Law 104-191; Health Insurance Portability and Accountability Act (HIPAA) of 1996.
2. The policy follows the rules as explained in the Code of Federal Regulations:

    A. 45 CFR, Part §160, General Administrative Requirements.
    B. 45 CFR, Part §162, Administrative Requirements.
    C. 45 CFR, Part §164, Security & Privacy.

3. Additional clarification regarding PHI per North Carolina legislative guidelines are found in North Carolina General Statutes:

    A. North Carolina General Statute § 8-53.6.
    B. North Carolina General Statute § 8-53.13.
    C. North Carolina General Statute § 130A-12.
    D. North Carolina General Statute § 130A-143-144.

4. All health department workforce will follows the guidelines as stated in each of the sections of this policy. The Sections include:

    Section 1: Introduction to HIPAA
    Section 2: Notice of Privacy Practices
    Section 3: Uses and Disclosures of Protected Health Information Not Requiring Patient Authorization
    Section 4: Uses and Disclosures of Protected Health Information Requiring Patient Authorization
    Section 5: "Minimum Necessary" Use and Disclosure of Protected Health Information (PHI)
    Section 6: Uses and Disclosures of Protected Health Information Where the Patient Has an Opportunity to Agree or Object
    Section 7: Access of Individuals to Protected Health Information
    Section 8: Accounting for Disclosure of Protected Health Information
    Section 9: Amendment of Protected Health Information
    Section 10: Business Associates
    Section 11: Safeguarding Protected Health Information
    Section 12: Training
    Section 13: Complaints to the Practice; Mitigation
    Section 14: No Retaliation for the Exercise of Rights or the Filing of a Complaint; No Waiver of Rights
    Section 15: Sanctions for Violations; Exceptions to Sanctions
    Section 16: Communication by Texting, Appointment Card, Phone Call & Letter

Sampson County Health Department
Section 1: Introduction to HIPAA

Purpose:

To provide guidance to all Sampson County Health Department (SCHD) workforce regarding the Health Insurance Portability & Accountability Act (HIPAA) of 1996 laws, rules and regulations as they relate to the privacy and confidentiality of the protected health information (PHI) for all health department patients.

Policy:

The HIPAA Privacy Rule provides that patients have a right to notice of how we may use and disclose a patient's PHI; the patient's rights; and SCHD's obligations regarding their PHI. SCHD will strive to abide by the terms of the Notice as currently in effect.

The Sampson County Health Department (SCHD) provides policies and procedures as required by and specified in the privacy rule of the Administrative Provision in the Health Insurance Portability and Accountability Act of 1996 and North Carolina General Statutes as they related to patient health information.

Definitions:

This Manual has a Glossary of Terms that explains terms used in the Manual – refer to the Appendix, Attachment A.

Applicable Laws, Rules and Regulations:

USC Public Law 104-191: Health Insurance Portability & Accountability Act (HIPAA) of 1996.
45 CFR, Part §160, General Administrative Requirements.
45 CFR, Part § 162, Administrative Requirements.
45 CFR, Part § 164, Security & Privacy.
North Carolina General Statute § 8-53.6.
North Carolina General Statute § 8-53.13.
North Carolina General Statute § 130A-12.
North Carolina General Statute § 130A-143-144.

Responsible Persons:

Sampson County Health Department workforce

Procedures:

The following is an overview and introduction to the HIPAA law of 1996 and subsequent rules and regulations to ensure the privacy of patient health information.

What is the HIPAA Privacy Rule?

1. To improve the efficiency and effectiveness of the health care system, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") was enacted by Congress. HIPAA included what are called "Administrative Simplification" provisions that required the U.S. Department of Health and Human Services ("HHS") to adopt national standards for electronic health care transactions, such as health care claims that are filed electronically.
2. Because advances in electronic technology could make it difficult to protect the privacy of health information, Congress mandated the adoption of the HIPAA Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule" or "Rule").
3. Congress subsequently enacted the HIPAA Security Rule and, more recently, the Health Information Technology for Economic and Clinical Health (HITECH) Act.
4. In addition, North Carolina has enacted laws regarding identity theft prevention, data security breach notification and protected use and disclosure of Social Security numbers (see the SCHD Data Breach Notification Policy). The Rule does not replace other federal, state or other laws that give individuals even greater privacy protections, and are not preempted by the Privacy Rule.
5. The Privacy Rule establishes national protections for the privacy of protected health information ("PHI"), and applies to three types of HIPAA covered entities: health plans, health care clearinghouses, and health care providers, to include the Sampson County Health Department (SCHD), that conduct certain health care transactions electronically. The Rule requires that Covered Entities implement policies and procedures to protect and guard against the misuse of PHI.
6. The HIPAA Manual reflects the commitment to compliance with the Privacy Rule.

Privacy Officer:

1. The Privacy Rule requires that an agency designate a person who will serve as the "Privacy Officer" and who is responsible for the development and implementation of the privacy policies and procedures.
2. The agency must also designate a person to serve as the contact person responsible for receiving complaints under the Privacy Rule and who can make further information available to patients about matters covered by the Notice of Privacy Practices.
3. The Health Director has been designated as the Privacy Officer for SCHD, to be responsible for the development and implementation of SCHD privacy policies and procedures, and to be the contact person to answer questions and receive complaints related to the privacy practices.

What does the HIPAA Privacy Law mean to the Sampson County Health Department and SCHD workforce?

1. All SCHD workforce need to understand what the basic Privacy Policies and Procedures are and how to request help if further information is needed.
2. This policy will be posted on SharePoints and will be available to all SCHD workforce.
3. Each workforce member will be required to review the policies and the Notice of Privacy Practices and participate in training that will be offered on the Privacy Rule.
4. If the Privacy Rule changes, or new guidance is issued that requires a change in the

Policy Manual, the agency will have each member of the workforce review the changed policies.

5. SCHD is committed to providing quality health care to the patients, while maintaining the privacy of their protected health information (PHI) and complying with the Privacy Rule.

Sampson County Health Department
Section 2: Notice of Privacy Practices

Purpose:

To provide guidance for the HIPAA Privacy Rule that provides patients with the right of notice of how SCHD may use and disclose a patient's protected health information (PHI), as well as the patient's rights and SCHD's obligations regarding their PHI. A Notice of Privacy Practices has been developed to meet the requirements and make the Notice available to SCHD patients as described in this policy. SCHD will abide by the terms of the Notice of Privacy Practices that is currently in effect.

Policy:

The Sampson County Health Department (SCHD) will implement policies and procedures as required by and specified in the privacy rule of the Administrative Provision in the Health Insurance Portability and Accountability Act.

Definitions:

This Manual has a Glossary of Terms that explains terms used in the Manual – refer to the Appendix, Attachment A.

Applicable Laws, Rules and Regulations:

USC Public Law 104-191: Health Insurance Portability & Accountability Act (HIPAA) of 1996.
45 CFR, Part **§** 164.514.
45 CFR, Part § 164.520.

Responsible Persons:

All Sampson County Health Department workforce.

Procedures:

Content of Notice:

1. The Notice of Privacy Practices ("Notice") is written in plain language to contain all of the elements required by the Privacy Rule, including the following:

    A. A description of how the health department will use and disclose patients' PHI, including:

        1. A description, with at least one example, of the types of uses and disclosures that are permitted to make for treatment, payment, and health care operations.

2. A description of each of the other purposes that are permitted or required by HIPAA to use or disclose PHI without the patient's written authorization.
3. A statement that other uses and disclosures will be made only with the patient's written authorization (see Section 4 of Manual).

B. A description of the individual rights of SCHD patients regarding access and control of their PHI, and how a patient may exercise those rights, including:

1. The right to request restrictions on certain uses and disclosures and whether the health department is required to agree to a requested restriction, including agreeing to the request of a patient to restrict disclosure of PHI about him/her to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and the PHI pertains solely to a health care item or service for which the patient, or person other than the health plan, has paid SCHD in full for the item or service.
2. The right to receive certain confidential communications.
3. The right to inspect and obtain a copy of PHI.
4. The right to request an amendment of PHI.
5. The right to receive an accounting of certain disclosures of PHI.
6. The right to revoke an authorization.
7. A description of SCHD's complaint procedure for addressing problems the patient may have with SCHD's privacy practices.
8. The right to obtain a paper copy of the Notice, upon request.

2. If SCHD maintains an electronic health record, patients have the right to:

A. Access to or obtain a copy of PHI in an electronic form and format requested by the patient, if it is readily producible or, if not, in a readable electronic form and format as agreed to between SCHD and the patient.
B. Have SCHD transmit such copy directly to a person or entity the patient designates, provided that choice is clear, conspicuous, and specific.
C. Request that SCHD provide an accounting of the disclosures made of the patient's PHI, including disclosures related to treatment, payment and health care operations contained in an electronic health record for no more than 3 years prior to the date of the request (and depending on when SCHD acquired an electronic health record).
D. Notice of any allowed fees related to the above.

3. Patients have a right to and may request:

A. A description of SCHD's legal duties regarding PHI, including the legal obligation to maintain the privacy of PHI and the obligation to notify affected individuals following a breach of their unsecured PHI.
B. Identification of whom in the health department a patient may contact for more information about SCHD's privacy practices.

C. The effective date of the Notice and any revisions of the Notice, with the effective date of such revisions.

Providing the Notice:

1. The Privacy Notice will be presented to each patient at their first date of service delivery by SCHD.
2. Front Desk/Intake-Eligibility Staff will make a good faith attempt to obtain each patient's acknowledgment of the receipt of the Privacy Notice.
3. SCHD will have a patient acknowledge receipt by signing an acknowledgment form.
4. If the patient refuses to provide such acknowledgment, SCHD will document in the patient's chart the efforts to obtain the patient's acknowledgment and the reason why the acknowledgment was not obtained.
5. If there is an emergency treatment situation, SCHD will provide the Notice to the patient as soon as reasonably practicable after the emergency situation is resolved. No acknowledgment of receipt of the Notice needs be obtained in an emergency situation.
6. SCHD has posted the entire current Notice at the Front Desk Reception area.
7. SCHD will provide a paper copy of the Notice upon a patient's request.
8. If the patient has a personal representative acting on the patient's behalf at the time Notice is provided, SCHD will provide the Notice to the representative and make a good faith effort to obtain the representative's acknowledgment of receipt of the Notice.

Revisions & Reviews to the Privacy Notice:

1. SCHD will advise patients in the Notice that SCHD reserves the right to change the terms of the Notice and to make the new Notice provisions effective for all PHI that is maintained.
2. SCHD will review the Privacy Notice at least annually. If SCHD determines at any time that there is a material change to the agency's privacy practices, or there is a change in law that requires a change in the Privacy Notice, SCHD will:

   A. Revise the Privacy Notice.
   B. Date it with the effective date of the revision.
   C. Post the revised Notice in at the Front Desk, Intake cubicles and exam rooms, then implement the changes (unless a change in law requires that SCHD implement the change sooner).
   D. Provide the revised Notice pursuant to this Policy.
   E. Patients will be notified in the SCHD revision Notice that they can obtain a revised Notice upon request on or after the effective date of any revision.

3. No acknowledgement is necessary for providing a revised/reviewed Privacy Notice to a patient who has received a prior version of the Notice.
4. SCHD may utilize a "layered" Notice that consists of a short notice summarizing the patient's rights, attached to a longer notice that contains all of the elements listed in Parts 1 or 2 of this Policy. The patient will be provided with the two documents stapled together, with the shorter notice on top of the longer notice.

Documentation:

1. The Privacy Officer will maintain a file containing a copy of the SCHD Privacy Notice and each revised Notice that is issued by SCHD.
2. SCHD will place in the patient's medical record a copy of the acknowledgment of receipt (which will also contain a reference to the version of the Notice they received), whether provided by hard copy or electronically, or documentation of workforce's good faith efforts to obtain such written acknowledgment.

Sampson County Health Department
Section 3: Uses and Disclosures of Protected Health Information (PHI)

Purpose:

To establish guidelines for the use and disclosure of Protected Health Information (PHI).

Policy:

The Sampson County Health department (SCHD) may use and disclose PHI in certain situations where it is not necessary to obtain the patient's authorization, as allowed under the HIPAA Law Privacy Rule. SCHD will follow Section 5 of this Manual regarding application of the Minimum Necessary principle when using or disclosing PHI without patient authorization.

Definitions:

This Manual has a Glossary of Terms that explains terms used in the Manual – refer to the Appendix, Attachment A.

Applicable Laws, Rules and Regulations:

USC Public Law 104-191: Health Insurance Portability & Accountability Act (HIPAA) of 1996.
45 CFR, Part **§** 164.502.
45 CFR, Part § 164.506.
45 CFR, Part **§** 164.514.
45 CFR, Part § 164.521.
North Carolina General Statute § 130A-12.

Responsible Persons:

All Sampson County Health Department workforce

Procedures:

In the following situations, the health department may use or disclose PHI without obtaining the patient's authorization:

For Treatment, Payment or Health Care Operations:

1. A patient's authorization is not required when SCHD uses or discloses the patient's PHI for SCHD purposes in order to treat the patient, obtain payment for the services, or conduct SCHD business operations, including disclosure to the agency's business associates (as further described in this Manual).
2. Sampson County Health Department requires a signature on the authorization from a patient on the first visit to the department. The authorization must:

    A. Inform the individual that PHI may be used and disclosed to carry out treatment,

payment and health care operations (TPO).

B. Refer the individual to the Sampson County Health Department's Notice of Privacy Practices for a more complete description of such uses and disclosures.
C. State that the individual has the right to review the notice prior to signing the consent.
D. State that the individual has the right to revoke the consent in writing, except to the extent that the Sampson County health department has taken action in reliance on the consent.
E. Be signed, and dated by the individual and witness.

3. A patient is permitted to request, in writing, that SCHD restrict the uses or disclosures of his or her PHI for treatment, payment or health care operations, or when disclosing information to persons involved in the patient's care, or for notification purposes. Except as set forth below, SCHD is not required to agree to the patient's request, but are bound by any restrictions to which SCHD agrees unless and until SCHD withdraws from such agreement, where permitted. Such requests will be directed to the SCHD Privacy Officer.
4. If a patient requests that SCHD restrict the disclosure of the patient's PHI to his/her health plan, the health department must comply if:

   A. The disclosure is not for purposes of carrying out treatment (only for purposes of carrying out payment or health care operations); and
   B. The PHI pertains solely to a health care item or service for which the health department has been paid out-of-pocket in full.

5. A patient is permitted to request, in writing, that the patient receive communications of PHI from SCHD by alternative means or at alternative locations (other than the usual way SCHD sends communications to patients). SCHD must accommodate a patient's reasonable request for such confidential communications. Such requests will be directed to the SCHD Privacy Officer.
6. Special rules apply if the patient's file contains psychotherapy notes, if SCHD intends to use the PHI for marketing purposes or if SCHD intends to use PHI in a manner that would be considered a ***Sale of PHI*** (see Glossary of Terms). Such cases will be referred to the SCHD Privacy Officer.
7. SCHD may disclose PHI for the treatment activities of another health care provider. Where PHI is disclosed to, or requested by, other health care providers for treatment purposes, SCHD's Minimum Necessary Policy (Section 5) does not apply.
8. SCHD may disclose PHI to another Covered Entity for the peer review activities of that entity, subject to review and approval by the SCHD Privacy Officer.
9. Any use or disclosure of PHI for Treatment, Payment or Health Care Operations must be consistent with SCHD's current Notice of Privacy Practices.

Required Uses and Disclosures Not Requiring Patient Authorization:

Other than for disclosures to the patient, no disclosure under this Section will be made without the prior review and approval of the SCHD Privacy Officer who may consult with the County's legal counsel.

Disclosures to the Patient:

Under the law, except as provided in Section 7 of this Manual, SCHD must make disclosures *to the patient* who requests such disclosure and no authorization is required. If the patient requests a copy of his or her record, refer to Section 7 of this Manual.

Disclosures to the Secretary of HHS/OCR:

SCHD must make disclosures of PHI when required by the Secretary of HHS or to the Office of Civil Rights (OCR) to investigate or determine SCHD's compliance with the requirements of the Privacy Rule.

Disclosures as Required by Law:

To the extent that the use or disclosure of PHI is required by an applicable law, SCHD may do so without the patient's authorization, in compliance with, and limited to, the relevant requirements of such law.

Disclosures for Public Health Activities:

SCHD may use or disclose a patient's PHI, without the patient's authorization, for the following public health activities and purposes:

A. Public Health Authorities: Disclosure to a public health authority that is legally authorized to receive such information for the purpose of:

    1. Preventing or controlling disease, injury or disability, such as reporting of injury or communicable disease.
    2. Vital events such as birth and death.
    3. Public health surveillance, investigation and/or public health intervention.
    4. If directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

B. Communicable Diseases: In addition to reporting communicable disease information to a public health authority as provided for in Subsection A above, SCHD may disclose a patient's PHI, as authorized by state law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Disclosures for Abuse or Neglect:

A. Children: SCHD may disclose a patient's PHI to a public health/legal authority that is authorized by law to receive reports of child abuse or neglect.
B. Adults: Except for vulnerable adults, if SCHD believe that an adult patient has been a victim of abuse, neglect or domestic violence, SCHD may disclose a patient's PHI to the governmental entity or agency authorized by law to receive such information. No disclosure of information about the victim of domestic violence or abuse may be made to law enforcement without the patient's authorization.

C. Vulnerable Adults: When a vulnerable adult is the subject of abuse, neglect or exploitation, SCHD may disclose the patient's PHI to the appropriate government adult protective services provider.

Disclosures for Health Oversight:

SCHD may disclose PHI to a health oversight agency for activities authorized by law, such as audits; civil, criminal or administrative investigations, proceedings or actions; inspections; or licensure or disciplinary actions.

Disclosures for Legal Proceedings:

SCHD may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (but only that PHI for which disclosure is expressly authorized), and, under certain conditions, in response to a subpoena, discovery request or other lawful process. SCHD workforce will direct all subpoenas, and other requests for disclosures for purposes of legal proceedings, to the SCHD Privacy Officer who may consult the County's legal counsel.

Disclosures for Law Enforcement:

SCHD may disclose PHI for law enforcement purposes, without a patient's authorization, so long as specific legal requirements are met. Some of these law enforcement purposes include: warrants and other legal process; limited information requests for identification and location purposes; and information related to a crime (including a medical emergency where it is likely that a crime has occurred). SCHD workforce will direct all law enforcement requests for disclosures to the SCHD Privacy Officer who may consult the County's legal counsel.

Disclosures for Coroners, Medical Examiners, Funeral Directors, and Organ Donations:

1. SCHD may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other official duties.
2. SCHD may disclose PHI to a funeral director, as authorized by state law, in order to permit the funeral director to carry out his or her duties, including disclosure prior to, and in reasonable anticipation of, the death of a patient, if necessary for the funeral director to carry out his or her duties.

Disclosures for Research:

If SCHD is requested to use or disclose PHI for research purposes, such use and disclosure will be under the direction of the SCHD Privacy Officer who will consult with the County's legal counsel.

Disclosures for Serious Threat to Health or Safety:

Under certain circumstances, SCHD may use a patient's PHI, or disclose it to another health care professional or to a law enforcement agency, if SCHD believes, in good faith, that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of

the patient or to others or is necessary in certain situations for law enforcement authorities to identify or apprehend an individual who is a serious threat to public safety. If the PHI contains identifying information about a person who has AIDS or an HIV infection, SCHD will not disclose such information without the patient's authorization, unless authorized by state law, or pursuant to a court order.

Disclosures for Specialized Government Functions:

When the appropriate conditions apply, SCHD may use or disclose a patient's PHI for certain military, national security or intelligence activities, or when needed for correctional institutions and other law enforcement custodial situations.

Disclosures for Workers' Compensation:

A patient's PHI may be disclosed by SCHD as authorized under state law to comply with workers' compensation laws and other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault. For routine disclosures for workers' compensation purposes, SCHD follows the standard protocols for such disclosures as part of the Minimum Necessary Policy – see Section 5.

Disclosures for Schools; Immunization Records:

SCHD may disclose a patient's PHI to a school when the patient is a student or a prospective student of the school if:

1. The PHI that is disclosed is limited to proof of immunization;
2. The school is required by state law (or other law) to have proof of immunization prior to admitting the individual; and
3. SCHD obtains and documents the oral agreement for such disclosure from the parent, guardian or other person acting in loco parentis of an emancipated minor or from the individual, if the individual is an adult or emancipated minor.

Verification of the Identity of an Authorized Person:

1. Prior to any disclosure of PHI under this policy, SCHD will verify the identity of the person requesting the PHI and the authority of any such person to have access to the patient's PHI, if the identity or any such authority of the person is not known to us.
2. SCHD will obtain and/or document any pertinent credentials, documentation, statements or representations, whether oral or written, from the person requesting the PHI.

Sampson County Health Department
Section 4: Uses and Disclosures of Protected Health Information Requiring Patient Authorization

Purpose:

To establish guidelines for the use and disclosure of protected health information (PHI).

Policy:

The Sampson County Health department(SCHD) may use or disclose a patient's PHI for those purposes specified in Section 3 of this Manual without obtaining the patient's authorization. Other uses and disclosures of PHI, as addressed in this policy, will be made only with the patient's written authorization. The health department will not condition treatment on the provision by the patient of a requested authorization except as allowed under this policy.

Definitions:

This Manual has a Glossary of Terms that explains terms used in the Manual – refer to the Appendix, Attachment A.

Applicable Laws, Rules and Regulations:

USC Public Law 104-191: Health Insurance Portability & Accountability Act (HIPAA) of 1996.
45 CFR, Part **§** 164.508.
45 CFR, Part § 164.514.

Responsible Persons:

All Sampson County Health Department workforce

Procedures:

Overview:

Whenever the health department needs to use or disclose a patient's PHI for purposes unrelated to Treatment, Payment or Health Care Operations (or as otherwise described in Section 3), or if a patient requests disclosure of his or her PHI to a specified third party, we will obtain the patient's written authorization prior to such use or disclosure. SCHD will only release PHI that is consistent with the scope of the authorization.

Authorization Form:

The health department's authorization form will provide for the following:

1. The name of the person or entity, or category of persons/entities authorized to make the requested use or disclosure.

2. The name of the person or entity, or category of persons/entities, to whom the use or disclosure may be made.
3. Specifically describe the information to be used or disclosed, including, but not limited to, specific detail such as date of service, type of service provided, level of detail to be released, origin of information, etc.
4. List the specific purposes for the use or disclosure. If the individual does not, or elects not to, provide a statement of the purpose, the form will state the purpose as "at the request of the individual."
5. Specify that the authorization will be in force and effect until a specified date or event (stated in the authorization) that relates to the patient or to the purpose of the use or disclosure, at which time the authorization will expire.
6. Provide for the patient's right to revoke the authorization as set forth in "Revocation of Authorization" #1 and #2 below.
7. Specify that the health department will not condition treatment upon the patient's execution of an authorization, as set forth in "Revocation of Authorization" #3 below.
8. Specify that the information disclosed pursuant to the authorization may be re-disclosed by the recipient and is no longer subject to the protections of the Privacy Rule.
9. Provide for the patient's signature and date of execution or, if the patient's Personal Representative is signing on behalf of the patient, provide for a description of that person's authority to act and/or that person's relationship to the patient.

Revocation of Authorization:

1. A patient has the right to revoke an authorization at any time, in writing, by mailing such written notification to the attention of the health department's Privacy Officer or by personal delivery to the Privacy Officer.
2. A revocation is not effective to the extent that the health department has taken action in reliance on the patient's authorization.
3. The health department will not condition a patient's treatment on whether the patient provides authorization for the requested use or disclosure if to do so would be prohibited by federal or state law. If a reason exists under law for conditioning the patient's treatment on obtaining an authorization, the patient will be advised of that fact and of the consequences to the patient of refusing to sign the authorization. The Privacy Officer will determine if such reason exists.

Independent Medical Examination:

In accordance with state law, if a third party has requested that the health department examine or evaluate a person ("Examinee") and the Examinee has signed an authorization for the release of the report of such examination or evaluation to the third party:

1. The report will be consistent with the authorization, to avoid unnecessary disclosure of diagnoses or personal information which is not pertinent to the evaluation.
2. The report will be forwarded only to the third party who requested the evaluation, in accordance with the Examinee's authorization and, if no specific individual is identified, the report will be marked "Confidential"; and
3. SCHD will not provide the Examinee with a copy of the report unless the third party requesting the examination consents to its release, except that should the

examination disclose abnormalities or conditions not known to the Examinee, SCHD will advise the Examinee to consult another health care professional for treatment.

4. SCHD will refer the following requests to the Privacy Officer for complying with such requests in accordance with law.

   A. PHI that contains psychotherapy notes.
   B. PHI for marketing purposes.
   C. PHI for research purposes.
   D. A request for a use or disclosure that may be considered a sale of PHI.

5. SCHD will not directly or indirectly receive remuneration in exchange for any PHI of a patient unless the agency has obtained a valid authorization that includes a specification of whether the PHI can be further exchanged for remuneration by the entity receiving the patient's PHI. This requirement will not apply if the purpose of the exchange is:

   A. For public health activities;
   B. For research and the price charged reflects the costs of preparation and transmittal of the data for such purposes;
   C. For treatment and payment purposes;
   D. For the sale, transfer, merger or consolidation of all or part of the health department with another Covered Entity, and due diligence related to such activity;
   E. For remuneration that is provided by the health department to a Business Associate for activities involving the exchange of PHI that the Business Associate undertakes on SCHD's behalf and at the agency's specific request pursuant to a Business Associate Agreement;
   F. To provide a patient with a copy of the patient's PHI pursuant to Section 7 of this Manual;
   G. As required by law; or
   H. For any other purpose permitted by or in accordance with the Privacy Rule where the only remuneration received by SCHD is a reasonable, cost-based fee to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by other law.

6. Any offer of remuneration in exchange for PHI will be directed to the SCHD Privacy Officer.
7. Prior to any disclosure of PHI under this policy, SCHD will verify the identity of the person requesting the PHI and the authority of any such person to have access to the patient's PHI, if the identity or any such authority of the person is not known to SCHD; the agency will obtain any documentation, statements or representations, oral or written, from the entity requesting the PHI when such documentation, statement or representation is pertinent to the disclosure.
8. SCHD can accept a government agency's authorization form as long as it meets the requirements of "Authorization Form" #1-9 above.
9. The patient may receive a copy of the authorization, upon request.
10. SCHD workforce will document in the patient's medical record that the patient's authorization was obtained for the specific use or disclosure and will retain the signed authorization in the patient's medical chart, in either written or electronic form, for at least six years from the date when it last was in effect. If the patient revokes the

authorization, SCHD will document such revocation in the patient's medical record and retain the signed revocation in the same manner as an authorization.

Sampson County Health Department
Section 5: Minimum Necessary Use & Disclosure of PHI

Purpose:

To set forth the requirements for making reasonable efforts to limit the use and disclosure of individually identifiable health information (IIHI) and/or protected health information (PHI) to that which is minimally necessary.

Policy:

Except as otherwise stated in this policy, when Sampson County Health Department (SCHD) uses or discloses PHI, or when SCHD requests PHI from another Covered Entity or Business Associate, the SCHD will make reasonable efforts to limit the information to the extent practicable, to the Limited Data Set or, if needed by the health department, to the minimum necessary to accomplish the intended purpose of the use, disclosure or request, respectively.
The minimum necessary requirement applies to: 1) Uses or disclosures for payment or health care operations; 2) Uses or disclosures requiring the patient to have an opportunity to agree or object; 3) Uses or disclosures that are permitted without the patient's permission (except for those required by law or specified otherwise in the Sampson County Health Department HIPAA Privacy Rule Policy Manual; and 4) Uses or disclosures by External Business Associates.

Definitions:

This Manual has a Glossary of Terms that explains terms used in the Manual – refer to the Appendix, Attachment A.

Applicable Laws, Rules and Regulations:

USC Public Law 104-191: Health Insurance Portability & Accountability Act (HIPAA) of 1996.
45 CFR, Part § 164.502(b).
45 CFR, Part § 164.514(d).

Responsible Persons:

All Sampson County Health Department workforce

Procedures:

Exceptions to the Policy:

SCHD uses and disclosures of PHI, and requests for PHI, that are not subject to this policy requiring that the minimum necessary information be used or disclosed, are as follows:

1. Disclosures to or requests by a health care provider for treatment purposes, including SCHD's requests for disclosure of PHI for Treatment purposes.
2. Disclosures made to the patient, including but not limited to disclosures made to the patient pursuant to the patient's request to access his or her record or for an accounting of

disclosures made by SCHD of the patient's PHI;

3. Uses or disclosures made pursuant to a patient's authorization that meets the requirements of Section 4 of this Manual.
4. Disclosures made to the Secretary of HHS related to enforcement of the requirements of the HIPAA privacy standard.
5. Uses or disclosures required by other law as described in Section 3 of this Manual.
6. Uses or disclosures that are required for compliance with the requirements of the HIPAA privacy standard.
7. PHI that has been de-identified, as specified in the Privacy Rule.

Situations Where the Policy Applies:

1. Uses of PHI:

    A. SCHD has established which persons or categories of persons in the agency need access to PHI to carry out their duties.
    B. For each such person or category, SCHD has determined the types of PHI to which access is needed, including identification of those persons or classes of persons in the health department who need to see the entire medical record, and any conditions that exist for access (job role-based access).
    C. SCHD will make reasonable efforts to limit the access only to the amount of information needed by the person in order to carry out the duties of that position or to accomplish the required use.

2. Disclosures of PHI:

    A. For disclosures of PHI that SCHD makes on a routine and recurring basis, SCHD has established a standard protocol for limiting the PHI disclosed to the minimum amount reasonably necessary to achieve the purpose of the disclosure.
    B. For non-routine disclosures, SCHD has developed criteria designed to limit the PHI disclosed to the minimum information reasonably necessary to accomplish the purpose of the disclosure. SCHD will review requests for such non-routine disclosures on an individual, case-by-case basis for conformance with these criteria.
    C. The criteria for non-routine disclosures do not need to be applied when a request for disclosure is received in the following situations and the request appears to reasonably limit the disclosure to the minimum necessary under the particular circumstances of the request:

        1. Requests for disclosures received from a health care provider, health plan or health care clearinghouse.
        2. Requests for disclosures received from public officials in those situations identified in Section 3 of this Manual (No Authorization Required) and the public official represents that the information requested is the minimum necessary.
        3. Requests for disclosures received from a professional member of the health department, or from one of SCHD's business associates for the purpose of providing professional services to the agency, if the professional represents that the information requested is the minimum necessary for the stated

purpose.

4. Requests for disclosures received from a researcher with appropriate documentation from an Institutional Review Board or Privacy Board.

3. Requests for PHI:

   A. SCHD will limit any request for PHI made to another health care provider, a health plan, or a health care clearinghouse to that which is reasonably necessary to accomplish the needed purposes.
   B. For requests made on a routine and recurring basis, SCHD has a protocol that limits the PHI requested to the amount reasonably necessary to accomplish the needed purposes.
   C. For requests on a non-routine or non-recurring basis, SCHD have developed criteria designed to limit the request for PHI to the information reasonably necessary to accomplish the needed purposes. SCHD will review such non-routine requests on an individual basis for conformance with these criteria.

4. For both routine and non-routine disclosures and requests, SCHD has identified the circumstances under which the entire medical record is reasonably necessary for particular purposes.
5. SCHD will reasonably rely on requests from the business associate of another health care provider, health plan or health care clearinghouse for the disclosure of PHI as meeting the minimum necessary requirement for the intended purpose.
6. SCHD will make reasonable expenditures to implement technologically feasible approaches in complying with this Minimum Necessary Policy – see Section 11 of this Manual: Safeguarding PHI.

Sampson County Health Department
Section 6: Uses and Disclosures of Protected Health Information- Opportunity to Agree or Object

Purpose:

To establish guidelines for the use and disclosure of protected health information (PHI).

Policy:

The Sampson County Health Department (SCHD) may use and disclose PHI in certain situations where it is necessary or beneficial to involve others in the patient's health care or to notify others of the patient's status or condition. In these situations, the patient has the opportunity to agree or object to the use or disclosure of all or part of the patient's PHI for these purposes.

Definitions:

This Manual has a Glossary of Terms that explains terms used in the Manual – refer to the Appendix, Attachment A.

Applicable Laws, Rules & Regulations and Regulations:

USC Public Law 104-191: Health Insurance Portability & Accountability Act (HIPAA) of 1996.
45 CFR, Part **§** 164.510.
45 CFR, Part § 164.514.

Responsible Persons:

All Sampson County Health Department workforce

Procedures:

Uses and Disclosures:

1. SCHD will make the following disclosures for involvement in the patient's care and notification purposes:

    A. Disclosing to a family member, other relative, close personal friend of the patient, or any other person identified by the patient, PHI that is directly relevant to that person's involvement in the patient's health care or payment related to the patient's health care.
    B. Using or disclosing PHI to notify, or assist in the notification of, a family member, a personal representative of the patient or another person who is responsible for the patient's care, of the patient's location, general condition or death.
    C. Disclosing PHI to any person identified in 1.A and .B above, who was involved in the patient's care or payment for the patient's health care prior to the patient's death, PHI of the patient that is relevant to such person's involvement, unless doing so is

inconsistent with any prior expressed preference of the individual that is known to SCHD.

2. If the patient is present or otherwise available prior to using or disclosing their PHI in this way, and the patient has the capacity to make health care decisions, SCHD will only disclose the information if SCHD:

   A. Provides the patient with the opportunity to agree or object to the disclosure, and the individual does not express an objection (SCHD can inform the patient orally and accept the patient's oral agreement or objection and will document such agreement or objection in the patient's medical record); or
   B. Can reasonably infer from the circumstances, based on professional judgment, the patient does not object to the disclosure.

3. If the patient is not present, or it is impractical to offer the patient the opportunity to agree or object to a use or disclosure of their PHI in these situations, because the individual is incapacitated or an emergency exists:

   A. SCHD will use professional judgment to determine whether the disclosure is in the best interests of the patient; and
   B. If SCHD determine disclosure is appropriate, SCHD will disclose only that PHI which is directly relevant to the person's involvement in the patient's care or payment related to the patient's health care or needed for notification purposes.

4. If the patient is not present, SCHD will use professional judgment and experience with common practice to allow another person acting on the patient's behalf to pick up medical supplies, or other similar forms of PHI because it is in the patient's best interest.
5. SCHD may use or may disclose a patient's PHI to a public or private entity authorized to assist in disaster relief efforts for coordinating with them in notifying family members or other individuals involved in the patient's health care. In such situations, SCHD will still follow the procedures of Subsections 1 through 4 of this Policy if, in SCHD's professional judgment, to do so will not interfere with the ability to respond to the emergency circumstances.

Patient Request for Special Restrictions on Disclosures to Others:

A patient may request that SCHD restrict disclosures otherwise allowed under this Policy. Any such requests will be directed to the Privacy Officer who may consult with the County's legal counsel.

Sampson County Health Department
Section 7: Access of Individuals to Protected Health Information (PHI)

Purpose:

To outline the steps when an individual makes a request to inspect and obtain a copy of the Protected Health Information (PHI)

Policy:

The Sampson County Health Department (SCHD), in accordance with this policy, will provide a patient the right to inspect and obtain a copy of the patient's PHI for as long as the agency maintains the information.

Definitions:

This Manual has a Glossary of Terms that explains terms used in the Manual – refer to the Appendix, Attachment A.

Applicable Laws, Rules & Regulations and Regulations:

USC Public Law 104-191: Health Insurance Portability & Accountability Act (HIPAA) of 1996.
45 CFR, Part § 164.524.

Responsible Persons:

All Sampson County Health Department workforce

Procedures:

General Procedures:

1. A patient of SCHD can request to inspect and/or obtain a copy of their PHI that is maintained in a Designated Record Set and SCHD will provide such access, unless access is to be limited as required in this Policy.
2. A Personal Representative of a patient may also be permitted to access the patient's PHI, in accordance with this Policy.
3. If SCHD does not maintain the PHI that is the subject of the request and SCHD is aware of where the requested information is maintained, SCHD will inform the patient where to direct the request for access.

Requests for Access and Responding to Requests:

1. All requests for inspection and/or copying of a patient's PHI must be in writing.
2. Patients will be advised of the requirement in the Notice of Privacy Practices. The requests will be directed to the Privacy Officer.
3. SCHD may choose to provide a summary of the requested information. Patients will be advised in the Notice of Privacy Practices of this alternative. SCHD may only provide a

summary if the patient agrees in advance to receive a summary of their PHI.

4. The health department will respond to a request for inspection or copying within thirty (30) days of receipt of the written request.
5. If the patient requests, SCHD will mail the copy of the PHI or the summary of the PHI, as agreed upon, to another person specified by the patient if the patient's request is in a writing signed by the patient and clearly identifying the designated person and where to send the copy of the PHI.
6. If SCHD maintains an electronic health record that contains the PHI requested by the patient, the patient has the right to obtain a copy of that information in an electronic form and format they request, if it is readily producible; if not, a readable electronic form and format as agreed between SCHD and the patient will be provided.
7. The patient may choose to direct SCHD to transmit such copy directly to an entity or person designated by the patient, provided that any such choice is clear, conspicuous, and specific.
8. SCHD will charge a fee for the copy of the patient's PHI or for a summary of the PHI that is reasonable and cost-based, including in all cases any charge limits imposed by federal and/or state law.
9. Any fee imposed for providing an electronic copy or summary of PHI will not be greater than the labor costs accrued in responding to the request and the supplies for creating the electronic media if the individual requests that the electronic copy be provided on portable media, again as limited by federal or state law.
10. Patients will be notified in the SCHD Notice of Privacy Practices that a fee will be charged and patients will be advised of the fee.
11. SCHD will not refuse to provide a patient with a copy of his or her medical record due solely to the fact that the patient has an outstanding balance with the agency, when it is known to us that the record is needed by another health care professional for the purpose of rendering care to the patient. In all other cases, the copying fee must be paid prior to or at the time the copy is provided to the patient or personal representative. This includes clients calling in/walking in a requesting copies and clients that are in the building receiving services. The only exception will be clients in the building requesting a copy of their records for the services provided that day.
12. If the patient requests only to inspect his or her PHI, SCHD will arrange with the patient for a convenient time, no later than 30 days from the request, and place, if the inspection will not occur at SCHD.
13. All inspections of PHI by patients or personal representatives will be under the personal supervision of a designated SCHD staff member.
14. For any state or federal agency or official request, by subpoena or by demand for statement in writing under oath or otherwise, requests a patient's PHI, the SCHD Privacy Officer will contact the County legal counsel immediately.

Denying or Limiting Access:

1. SCHD may deny or limit access to a patient's PHI, ***without any right to a review of*** SCHD's decision, if the information:

    A. Is psychotherapy notes.
    B. Has been compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding.
    C. Is that of an inmate in a correctional institution and SCHD's Medical Providers

were acting under the direction of the correctional institution, and certain circumstances exist which prohibit providing a copy of PHI to the inmate (to be determined by the SCHD Privacy Officer).

D. Was obtained by SCHD in the course of research that includes treatment of the research participant, while the research is in progress, under certain circumstances (to be determined by the SCHD Privacy Officer).

E. Is subject to the Privacy Act, as required by that Act.

F. Was obtained by SCHD from someone other than a health care provider, under a promise of confidentiality, and the requested access would be reasonably likely to reveal the source of the information.

2. SCHD may deny or limit access to a patient's PHI, ***with the right to a review of SCHD's decision, in the following situations:***

   A. A licensed health care professional in the health department has determined that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person.

   B. The information references another person (unless such other person is a health care provider) and a licensed health care professional has determined that the access requested is reasonably likely to cause substantial harm to that other person.

   C. Access is requested by a personal representative of the patient and a licensed health care professional has determined that access by that person is reasonably likely to cause substantial harm to the patient or another person.

   D. A licensed health care professional has reason to believe that the patient's mental or physical condition will be adversely affected upon being made aware of the subjective information contained in the PHI (or a summary of the PHI); in this case, the PHI can be provided, if requested by the patient (with an accompanying notice setting forth the reasons for the original refusal) directly to the patient's attorney, another licensed health care professional, the patient's health insurance carrier (through an employee of the carrier), or to a governmental reimbursement program or to an agent of such program who has responsibility to review utilization and/or quality of care.

3. The determination of whether to deny or limit access will be made by a licensed medical provider of SCHD in conjunction with the Privacy Officer.

4. SCHD will provide a patient with a written notice of denial or limitation of access which will contain: the reason for such denial or limitation; a statement of the patient's right to a review of the denial, if such right exists; how to exercise the review rights; and a description of SCHD's complaint procedures (see Section 13 of this Policy Manual), including the name or title and telephone number of the SCHD Privacy Officer as the contact person.

5. If SCHD denies the patient access to some of his/her PHI, SCHD will, to the extent possible, give the patient access to any other of the patient's PHI requested by the patient, where no grounds exist to deny such access.

Appeal of a Decision to Deny Access:

1. A patient may request a review of a denial of access that was made based on one of the reasons under the "Denying or Limiting Access" section above.
2. Requests for review of a denial of access must be in writing and will be directed to the Privacy Officer who will promptly refer the request for review by the person designated pursuant to #3 below.
3. Review of the denial of access will, within a reasonable period of time, be performed by a physician or other licensed health care professional designated by the SCHD Privacy Officer and who did not participate in the original decision to deny access.
4. Where no other physician or licensed health care professional of SCHD Practice exists or is available, the review will be conducted by another health care professional designated by the SCHD Privacy Officer.
5. The health department will conduct the review within a reasonable period of time and will attempt to conduct the review within 30 days of the request for review. Once the review is complete, SCHD will promptly provide a written response to the patient setting forth the decision of the reviewing professional and will provide access or deny access based on that decision.
6. SCHD will maintain a copy of the inspection/copying request form in the patient's medical record, including documentation on the form of the response, and the results of any appeal and review that may have occurred.

Sampson County Health Department
Section 8: Accounting for Disclosures of Protected Health Information (PHI)

Purpose:

To outline the procedure to be followed when an individual requests an accounting of disclosures of his or her Protected Health Information (PHI) made by a covered entity as defined in this section.

Policy:

The Sampson County Health Department (SCHD) will provide patients with an accounting of disclosures of their PHI as required under federal and state law and regulations.

Definitions:

This Manual has a Glossary of Terms that explains terms used in the Manual – refer to the Appendix, Attachment A.

Applicable Laws, Rules and Regulations:

USC Public Law 104-191: Health Insurance Portability & Accountability Act (HIPAA) of 1996.
45 CFR, Part § 164.528.

Responsible Persons:

Health Department workforce

Procedures:

1. A patient of the SCHD may request and has a right to receive an accounting of disclosures the health department has made of the patient's PHI, except as limited by this Policy.
2. A patient may request an accounting for a time period of up to six (6) years prior to the date of his or her request. The accounting will include disclosures made to or by the business associates.
3. All requests must be in writing and will be directed to the SCHD Privacy Officer.
4. Accounting does not need to disclosures made:

    A. To carry out Treatment, Payment or Health Care Operations ("TPO") of SCHD, except as set forth in #8 below.
    B. To patients about their own PHI.
    C. Pursuant to an authorization made by the patient or the patient's personal representative regarding the patient's PHI.
    D. To individuals involved in the patient's care or for other allowed notification purposes.
    E. Incident to a use or disclosure otherwise permitted or required by the Privacy Rule and this Policy Manual.

F. For national security or intelligence purposes.
G. To correctional institutions or law enforcement officials.
H. As part of a Limited Data Set

5. In order to provide this accounting to the patients, SCHD will maintain a log or record of all disclosures, other than those excluded under #4 above, of a patient's PHI, for a six (6) year period along with a copy of every accounting made to a patient.
6. A request for an accounting of disclosures will be acted upon within sixty (60) days of receipt of the request.
7. A one-time thirty (30) day extension may be allowed if the patient has been notified, within the initial 60-day period, of the reasons for the delay and the date by which SCHD will provide the accounting.
8. SCHD may choose to provide an accounting of all disclosures made by the health department and by any Business Associate acting on SCHD's behalf; or an accounting of all disclosures made by SCHD and provide to the patient a list of all Business Associates acting on the behalf, including contact information for such Business Associates (such as mailing address, phone, and email address), in which case such Business Associates will provide an accounting of their disclosures upon a request made by SCHD's patient directly to the Business Associate. The SCHD Privacy Officer will determine which option is chosen.
9. For each disclosure for which SCHD is required to provide an accounting under this Policy, SCHD will maintain the following information and will provide the information in the accounting to the patient:

   A. The date of the disclosure.
   B. The name of the entity or person who received the PHI and, if known, the address of such entity or person.
   C. A brief description of the PHI disclosed.
   D. A brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure or, in lieu of such statement, a copy of a written request by the DHHS Secretary for a disclosure to investigate or determine SCHD's compliance with the HIPAA privacy standard or a written request received for a disclosure made under "Section 3: Uses and Disclosures of Protected Health Information Not Requiring Patient Authorization."

10. If, during the period covered by the accounting, SCHD have made multiple disclosures of PHI to the same person or entity for a single purpose, the accounting may provide:

    A. The information required in this Policy for the first disclosure during the accounting period.
    B. The frequency, periodicity, or number of the disclosures made during the accounting period.
    C. The date of the last such disclosure during the accounting period.

11. If any disclosures of a patient's PHI involved a particular research purpose, the SCHD Privacy Officer will determine the manner of the agency log of disclosures and the manner of disclosing the accounting to the particular patient.
12. ~~The first accounting provided to a patient in any 12-month period will be without charge.~~

~~13. SCHD will charge a reasonable, cost-based fee for each subsequent request for an accounting by the same patient within a 12-month period and will inform the patient in advance of the fee; the patient will have an opportunity to withdraw or modify the request for a subsequent accounting in order to avoid or reduce the fee.~~

12. Accounting disclosure summaries will be provided to the client at no cost.

13. SCHD will temporarily suspend a patient's right to receive an accounting of disclosures that the Health Department has made to a health oversight agency or law enforcement official (see Section 3 of this Policy Manual), for the time specified by such agency or official, if such agency or official has provided SCHD with a written statement that such an accounting to the patient would be reasonably likely to impede the agency's activities and specifying the time for which such a suspension is required. If the agency or official statement is made orally, SCHD will:

    A. Document the statement, including the identity of the agency or official making the statement.
    B. Temporarily suspend the patient's right to an accounting of disclosures subject to the statement.
    C. Limit the temporary suspension to no longer than thirty (30) days from the date of the oral statement, unless the appropriate written statement is submitted to us by the agency or official during that time.

Sampson County Health Department
Section 9: Amendment of Protected Health Information (PHI)

Purpose:

To comply with HIPAA requirements, which provides that individuals may seek to amend their Protected Health Information (PHI) maintained in a designated record set.

Policy:

The health department in accordance with this policy, will provide the patients the opportunity to request amendment of their PHI that we maintain and, where appropriate under this policy, the right to have their PHI amended.

Definitions:

This Manual has a Glossary of Terms that explains terms used in the Manual – refer to the Appendix, Attachment A.

Applicable Laws, Rules & Regulations:
USC Public Law 104-191: Health Insurance Portability & Accountability Act (HIPAA) of 1996.
45 CFR, Part § 164.526.

Responsible Persons:

Health Department workforce

Procedures:

Receiving and Acting Upon a Request for Amendment:

1. A SCHD patient can request to have his/her PHI amended. The SCHD Notice of Privacy Practices will advise all patients that such a request must be in writing and must state a specific reason supporting the requested amendment.
2. All requests for amendment of PHI will be directed to the SCHD Privacy Officer.
3. Action upon the request for amendment will occur within sixty (60) days of receipt.
4. A one-time extension of not more than thirty (30) days may be allowed if the health department, before the end of the initial sixty-day period, provides a written notice to the requestor of the reason for the delay and the date by which SCHD intends to complete its action on the request.
5. The Privacy Officer will track the progress of each request for amendment to attempt to ensure compliance with these timeframes.
6. The Privacy Officer will review the amendment request for the following elements:

    A. The reason for the requested amendment, such as how the information is

incorrect or incomplete.

B. Whether the requested amendment is for:

1. Administrative information; and/or
2. Medical information, including the source, if known, the date(s) of service, and the specific provider of service;

C. Whether the health department was the originator of the information.
D. The specific wording requested to correct the alleged inaccuracy or incompleteness.

7. The Privacy Officer will make a preliminary determination regarding whether an amendment request should be honored, and will then consult with the physician, other health care professional, or administrative staff person of SCHD who provided the care and/or made the entry that is the subject of the amendment.
8. If that physician, health care professional or administrative staff person agrees with the Privacy Officer's preliminary determination, the Privacy Officer will obtain final approval from a Medical Provider.
9. If such final approval is obtained, the Privacy Officer will proceed with the amendment or denial of amendment, pursuant to this policy.
10. If a determination as to whether to accept or deny the amendment cannot be made internally, the Privacy Officer will notify the County legal counsel and request a resolution of the disagreement.

<u>Denying a Request for Amendment:</u>

1. SCHD may deny a request for an amendment in the following situations:

A. SCHD did not create the information, unless the patient provides a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment.
B. The information is not part of the records for a patient.
C. The information would not otherwise be available for inspection (see Section 7 regarding Access to PHI).
D. The health department determines that the information in dispute is neither inaccurate nor incomplete.

2. If SCHD determines that it will deny a request for amendment, in whole or in part, the Privacy Officer will provide written notice to the requestor, within the timeframe stated in "Receiving and Acting Upon a Request for Amendment" #4 , advising of the decision to deny amendment, stating the reason for the denial, and advising of the complaint procedures – see Section 13 of this Policy Manual.
3. The written notice will also advise the requestor that the individual may submit to the Privacy Officer a written statement of disagreement with the denial, stating the basis for such disagreement.
4. In most cases, the length of the statement of disagreement will be limited to one (1) page, unless it is unreasonable in the particular circumstance to impose such a limit.
5. If the patient does not submit a statement of disagreement, the patient may request that

SCHD provide the patient's request for amendment, and the denial, with any future disclosures of the PHI that is the subject of the requested amendment.

6. If a statement of disagreement is received from a requestor, the Privacy Officer, in consultation with the pertinent physician, health care professional or administrative staff person, will determine whether to prepare a rebuttal statement. If a rebuttal statement is prepared, SCHD will provide a copy to the requestor.
7. The denial and the disagreement and rebuttal statement, if any--will be linked to the PHI in dispute by scanning and attaching these documents to the disputed information in the patient's record.
8. Whenever the disputed information is disclosed to another person or entity, the information will include the denial and, if any exists, the statement of disagreement and the rebuttal.
9. Alternatively, SCHD can provide a summary of any of the foregoing information.
10. If the patient has not submitted a statement of disagreement, SCHD will include the patient's request for amendment and the denial, or a summary of the information, with any future disclosure of the patient's PHI only if the patient has requested such action.
11. If such a subsequent disclosure is made using a standard transaction under the HIPAA Transaction Rule that cannot accommodate the denial, disagreement and rebuttal, SCHD will separately disclose the denial, disagreement, and rebuttal to the recipient of the transaction.

Accepting the Request for Amendment:

1. If a determination is made to make the requested amendment, the Privacy Officer will provide written notification to the requestor that the requested amendment has been approved and the exact wording of the amendment.
2. The SCHD Privacy Officer will seek the requestor's identification of, and agreement to, the relevant persons identified by the Privacy Officer as persons or entities with whom the amendment needs to be shared.
3. The requestor will have ten (10) days to object to the form of amendment or to the persons with whom the amendment will be shared. If no objection is received within that time period, the amendment will be made in the PHI and the identified parties notified.
4. The Privacy Officer will identify the records in the designated record set for the patient that are affected by the amendment and append or otherwise provide a link to the location of the amendment.
5. The Privacy Officer will, within a reasonable period of time (but no longer than thirty [30] days), take reasonable efforts, such as send written notification by certified mail with return receipt requested, to provide the exact wording of the amendment to:

    A. Such persons or entities that the patient has identified as having received the relevant portion of the patient's PHI from the health department; and
    B. Such persons, including SCHD business associate that SCHD has identified as having received the relevant portion of the patient's PHI from the health department and who may have relied, or could foreseeably rely, on such information to the detriment of the patient.

Making the Amendment:

1. The SCHD Privacy Officer, or his/her designee, will identify all media forms in which SCHD maintains the information to be amended, i.e., paper, microfiche, microfilm, automated data processing or other electronic medium, and will cross check across all systems and applications maintained by the agency to ensure that the amendment is made, stored (as necessary), and susceptible to audit trails.
2. In no case will the Privacy Officer, a physician or any other person of the SCHD delete, erase, and/or "white out" or otherwise obliterate medical information in a patient's record. Any correction or addition to a patient's PHI will be clearly identified as a correction or addition to the original and will be dated and initialed by the physician or other person who made the entry.

Requests for Amendment where SCHD was not the Originator of the Information:

1. If a request for amendment applies to information for which the health department was not the originator, the Privacy Officer will contact the requestor and advise the requestor to seek amendment from the originator of the information.
2. If the requestor notifies us of a reasonable basis to believe that the originator is no longer available to act on a requested amendment, the Privacy Officer will make a reasonable attempt to confirm the unavailability. If the originator's unavailability is confirmed, the health department will act on the request for amendment as though the health department created the information.

Amendments Received from Other Covered Entities:

1. If SCHD is informed by another health care provider, a health care plan or a health care clearinghouse of an amendment to a patient's PHI, SCHD will amend the patient's PHI that the agency maintains accordingly.
2. The Privacy Officer will:

    A. Document in the patient's record that the approved amendment has been received from another source and the identity of the source providing the amendment;
    B. Ensure that the amendment is properly made in the PHI that is held by the health department; and
    C. If the patient whose PHI is amended is a current patient of the health department, alert the treating provider(s) for that patient of the amendment that has been made.

Sampson County Health Department
Section 10: Business Associates

Purpose:

To establish guidelines and provide assurances from Sampson County Health Department (SCHD) business associates that the business associates will appropriately safeguard the protected health information (PHI) it receives or creates on behalf of SCHD.

Policy:

Before the Sampson County Health Department (SCHD) can disclose PHI to a Business Associate, or allow a Business Associate to create, receive, maintain or transmit PHI on the behalf, the health department will obtain satisfactory assurances that the Business Associate will use or disclose the PHI only as permitted or required by the Business Associate Agreement, will safeguard the PHI from misuse, will help the health department comply with its duties under HIPAA and the Data Breach Notification Rule, and will secure these same assurances from any Subcontractor of the Business Associate. The Business Associate cannot use or disclose PHI provided by us in any manner that would not be a permissible use or disclosure by the health department under the Privacy Rule.

Definitions:

This Manual has a Glossary of Terms that explains terms used in the Manual – refer to the Appendix, Attachment A.

Applicable Laws, Rules & Regulations:
USC Public Law 104-191: Health Insurance Portability & Accountability Act (HIPAA) of 1996.
45 CFR, Part § 164.103.
45 CFR, Part § 164.502(e).
45 CFR, Part § 164.504(e).
45 CFR, Part § 164.532 (d) & (e).

Responsible Persons:

Health Department workforce

Procedures:

Business Associates; Business Associate Agreements:

1. For each new arrangement in which SCHD plans to retain a person or entity to perform a function, activity or service on behalf of the agency, the Privacy Officer will first consult the definition of Business Associate in the Glossary of Terms to determine whether the person or entity is to be treated as a Business Associate of the health department.
2. The health department will enter into a written Business Associate Agreement with

every person or entity who meets the definition of a Business Associate as set forth in the Glossary. The Privacy Officer will consult the SCHD Business Associate Agreement and contact the the County legal counsel as necessary to assist in negotiation and/or preparation of the necessary agreement.

3. Any Business Associate Agreement the health department enters into will meet the requirements of 45 C.F.R. §164.504(e) (1).
4. If a Business Associate presents to the health department the Business Associate's own proposed Business Associate Agreement, the Privacy Officer will compare the proposed agreement to the SCHD Business Associate Agreement and contact the County legal counsel as necessary to assist in negotiation of necessary revisions to the proposed agreement(s).
5. If SCHD has a Business Associate Agreement with an existing Business Associate Agreement that does not address requirements under the Data Breach Notification Rule or is not in compliance with the HITECH Act, SCHD will enter into an Amended and Restated Business Associate Agreement and contact the County legal counsel as necessary for assistance.

Confidentiality Agreements:

If the Privacy Officer identifies a person or entity that is not a Business Associate and who may have more than incidental or inadvertent access or exposure to PHI held by the SCHD, the Privacy Officer will seek to enter into a confidentiality agreement with that person or entity and will obtain the advice of the County legal counsel as necessary.

Responding to Violations by a Business Associate:

1. If any SCHD workforce receives any information leading him/her to believe that a SCHD Business Associate (or an employee or agent of one of the Business Associates) is violating a provision of the Business Associate Agreement or is engaged in some activity that could result in a violation of SCHD privacy policies and procedures, that person will immediately notify and provide that information to the Privacy Officer.
2. The Privacy Officer will keep a record of information provided to him/her pursuant to #1 above. If the information provided appears credible, the Privacy Officer:

    A. Will contact the Business Associate to discuss the problem; or
    B. May contact the County legal counsel prior to contacting the Business Associate.

3. If the information received by the Privacy Officer reflects a pattern of activity or practice of the Business Associate that constitutes a material breach or violation of the Business Associate's obligations under the agreement with that entity or person, the Privacy Officer will notify the County legal counsel for further action as required by the HIPAA Privacy Rule.

Sampson County Health Department
Section 11: Safeguarding Protected Health Information (PHI)

Purpose:

To establish guidelines for safeguarding protected health information (PHI).

Policy:

The health department will provide appropriate administrative, technical, and physical safeguards to try to reasonably safeguard the patients' PHI.

Definitions:

This Manual has a Glossary of Terms that explains terms used in the Manual – refer to the Appendix, Attachment A.

Applicable Laws, Rules & Regulations:

USC Public Law 104-191: Health Insurance Portability & Accountability Act (HIPAA) of 1996.
45 CFR, Part § 164.530 (c).

Responsible Persons:

Health Department workforce

Procedures:

Safeguard Implementation:

1. The health department will implement safeguards to reasonably:

    A. Protect SCHD patients' PHI from intentional or unintentional use or disclosure in violation of the Privacy Rule and the policies and procedures; and
    B. Limit incidental uses or disclosures that may occur as a result of an otherwise permitted or required use or disclosure of PHI.

2. In determining what type of safeguards to implement, SCHD will take into consideration agency needs and circumstances, such as:

    A. The nature of the PHI held.
    B. The potential risks to patients' privacy
    C. The potential effects on patient care.
    D. The financial and administrative burden of implementing particular safeguards.

Types of Safeguards:

Types of safeguards include:

1. Development, implementation, and periodic review and revision of the policies and procedures in HIPAA Policy Manual.
2. The designation of the Privacy Officer as the person responsible for implementing policies and procedures, receiving complaints, and, along with his/her designee, providing information regarding SCHD's Notice of Privacy Practices.
3. ~~Proper storage and disposal of documents and records, such as shredding documents and records prior to disposal.???????~~
4. ~~Speaking quietly when discussing a patient's condition with family members in a waiting room or other public area.?????~~
5. ~~Avoiding use of patients' names in public hallways and other public areas of the agency. ?????~~
3. Examples of types of safeguards may include:

    A. Proper storage and disposal of documents and records
    B. Speaking quietly when discussing a client's condition with family members in the lobby or other public area.
    C. Avoiding use of clients' name in public hallways and other public areas of the agency.
    D. Refer to the SCHD Information Security Policy for further details.

4. In areas where multiple patient-staff communications routinely occur, use of private offices with doors, cubicles, dividers, shields, curtains, or similar barriers as is reasonable for the agency.
5. Posting signs to remind employees to protect patient confidentiality.
6. Utilizing a patient sign-in sheet that does not include any of a patient's health information and, when calling out patient names or addressing patients in the waiting area, limiting the information disclosed, such as referring the patients to an area in the agency where they can receive further instructions in a more confidential manner.
7. Eliminating the posting of PHI in public areas where unauthorized persons can view the information.
8. Isolating or locking file cabinets or records rooms, or otherwise restricting medical records from access by unauthorized persons, such as maintaining reasonable supervision of these areas.
9. Computer Use:

    A. When maintaining computers outside of exam rooms, using such measures as reasonably limit access to these areas, such as ensuring that the area is supervised, escorting non-SCHD workforce in the area, and/or placing patient records in their holders with identifying information facing the door or wall or otherwise covered to ensure health information about the patient is not visible to others.
    B. Imposing security measures on computers and other systems containing PHI, such as restrictions on workstation use, unique user ID's and strong passwords to access such computers, and firewalls.
    C. Limiting visual access to computer monitors to avoid incidental disclosure of information to unauthorized persons by utilizing screen protectors, automatic

screen-savers with password re-entry, inactive screen time limits and automatic log-off.

10. Determining which SCHD workforce has access to keys and/or combinations to gain access to offices and/or to areas housing PHI and limiting such access to those whose duties require this level of access.
11. Establishing a disaster recovery plan, both for paper and electronic records.
12. Establishing a reporting and response system for security violations, in conjunction with SCHD's Data Breach Notification Policy.
13. Providing periodic security awareness training to SCHD workforce – see Section 12: Training.

References:

SCHD Information Security Policy 2018

Sampson County Health Department
Section 12: Training

Purpose:

To establish and provide training for the Sampson County Health Department (SCHD) workforce.

Policy:

The Sampson County Health Department will provide training to all SCHD workforce on the policies and procedures of the HIPAA Policy Manual, as necessary and appropriate for them to carry out their function and duties within the department.

Definitions:

This Manual has a Glossary of Terms that explains terms used in the Manual – refer to the Appendix, Attachment A.

Applicable Laws, Rules & Regulations:
USC Public Law 104-191: Health Insurance Portability & Accountability Act (HIPAA) of 1996.
45 CFR, Part **§** 164.530 (b).

Responsible Persons:

Sampson County Health Department workforce

Procedures:

1. The Privacy Officer will develop and implement a training program for SCHD workforce to include the following:

    A. Making a copy of the HIPAA Policy Manual available to all Members of SCHD workforce for:

        1. Reviewing each section of the Manual prior to training.
        2. Individual review of the Manual
        3. Consulting the Manual on an as-needed basis.

    B. Informal awareness training regarding privacy and security of PHI, including application of the minimum necessary principle for disclosure of PHI see Section 5.
    C. Periodic reminders about the need to make good faith efforts to maintain the privacy and security of SCHD patients' PHI.
    D. Education concerning computer virus protection, detection, and response to a virus infection.
    E. Education about the importance of a computer use requirements, secure login and SCHD's policy regarding creating, changing, and protecting the confidentiality of

computer passwords and other security measures.

2. The health department will provide HIPAA training as follows:

   A. To each new employee within thirty (30) days of hire.
   B. Annually to all SCHD workforce.
   C. To SCHD workforce whose job functions are affected by:

      1. A material change in SCHD's HIPAA policies and/or procedures; or
      2. A material change in the HIPAA Privacy Rule, with such training to occur within a reasonable period of time after the material change becomes effective.

   D. SCHD workforce will sign a log indicating the date and content of training received.

3. All new workforce will sign a confidentiality agreement stating that:

   1. The person has reviewed and understands SCHD's HIPAA privacy policies and procedures.
   2. The person will comply with the HIPAA policies and procedures.
   3. The person understands it is his/her responsibility to protect and maintain the privacy and security of SCHD patients' PHI.

4. The Privacy Officer will maintain records documenting that the training required by this policy is provided.

Sampson County Health Department
Section 13: Privacy Rule Complaints to the Agency -Mitigation

Purpose:

To address the patient's right to file a complaint if a person believes Sampson County Health Department (SCHD) is: not complying with the requirements of the HIPAA Privacy Rule or SCHD's privacy policies and procedures; or has complaints concerning the health department's own privacy policies and procedures.

Policy:

The Health Department will assure a patient's right to file a complaint with the Sampson County Health Department (SCHD) and the Secretary of the Department of Health and Human Services if the patient believes privacy rights were violated and will assure that complaint investigations meet the requirements of the privacy rule. This policy will establish the procedure for the reception, investigation and resolution of privacy complaints at the SCHD.

Definitions:

This Manual has a Glossary of Terms that explains terms used in the Manual – refer to the Appendix, Attachment A.

Applicable Laws, Rules & Regulations:

USC Public Law 104-191: Health Insurance Portability & Accountability Act (HIPAA) of 1996.
45 CFR, Part § 164.530 (d) & (f).

Responsible Persons:

Sampson County Health Department workforce

Procedures:

General Procedures:

1. A SCHD patient who has a complaint about HIPAA policies and procedures regarding the handling of PHI, about SCHD's compliance with such policies and procedures or with the Privacy Rule, may file a complaint with the Privacy Officer.
2. A complaint must be filed within 180 days in writing of when the person filing knew, or should have known, that the act of omission occurred, and must state the specific nature of the problem with SCHD policies and procedures or the specific area of alleged non-compliance.
3. The Privacy Officer will acknowledge to the patient, in writing, that SCHD received the complaint and that it will be addressed appropriately and a response provided to the patient.
4. As specified in Section 2: Notice of Privacy Practices, a patient may also file a complaint directly with the Office for Civil Rights (OCR) - see the Glossary.
5. The address for filing a complaint with the OCR will be provided to any person, upon

request:

Timothy Noonan, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services Sam Nun Atlanta Federal Center, Suite 16T70
61 Forsythe Street, S.W.
Atlanta, GA 30303-8909
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@dhhs.gov

6. A complaint to SCHD will be acted upon as soon as reasonably possible and at least within thirty (30) days of receipt of the complaint.
7. Upon receipt of a complaint, the Privacy Officer will review the complaint and may notify the County legal counsel for retention in reviewing, investigating, and formulating a response to the complaint.
8. Once the investigation into the complaint has been concluded, the Privacy Officer, in conjunction with legal counsel, will formulate an appropriate response to the complainant.
9. If the investigation of the complaint revealed a problem with SCHD policies and procedures, or a failure to comply with such policies and procedures or with applicable law or regulations, the Privacy Officer, in conjunction with the County legal counsel, will formulate corrective action intended to remedy the problem or non-compliance including, as appropriate, imposing sanctions pursuant to Section 15 of this Manual.
10. If the violation is found to involve a Business Associate of the department, SCHD will take the steps required by Section 10 of this Policy Manual, regarding the health department's Business Associates.
11. The SCHD Privacy Officer will document all complaints received and their disposition.
12. Any correspondence or communication SCHD receives from the OCR--whether regarding the investigation of a complaint, a compliance review, or otherwise--will be immediately provided to the Privacy Officer who will notify the County legal counsel to assist in responding to the OCR. Our Practice will cooperate with the OCR and provide access as required by the HIPAA Privacy Rule.

Mitigation:

1. The Privacy Officer will take reasonable efforts to mitigate, to the extent practicable, any harmful effect that is actually known to the department of a use or disclosure of PHI by SCHD or by one of the agency's Business Associates, in violation of SCHD's HIPAA policies and procedures or the requirements of law.
2. The Privacy Officer will implement SCHD's Data Breach Notification Section of the SCHD Information Security Policy, to determine if any notice is required and what mitigation efforts should be undertaken

Sampson County Health Department
Section 14: No retaliation for the Exercise of Rights/Filing Complaints/No Waiver of Rights

Purpose:

To assure that Sampson County Health Department (SCHD) patients have the right to file a complaint regarding privacy rules and not fear retaliation.

Policy:

The health department will not intimidate, threaten, coerce, discriminate against or take other retaliatory action against any individual who exercises, or attempts to exercise, his or her rights under the HIPAA Privacy Rule or who files a complaint or otherwise participates in HIPAA compliance efforts as described in this policy. Our Practice will not require an individual to waive his or her rights under the HIPAA Privacy Rule as a condition of receiving treatment from the Practice.

Definitions:

This Manual has a Glossary of Terms that explains terms used in the Manual – refer to the Appendix, Attachment A.

Applicable Laws, Rules & Regulations:
USC Public Law 104-191: Health Insurance Portability & Accountability Act (HIPAA) of 1996.
45 CFR, Part § 164.530 (g) & (h).

Responsible Persons:

Sampson County Health Department workforce

Procedures:

1. All requests for access, amendment, copying, authorizations, acknowledgments, and accountings related to the PHI of a patient of the health department will be handled in accordance with HIPAA laws and the SCHD HIPAA Policy Manual.
2. All complaints regarding privacy policies and procedures, or about SCHD compliance with the HIPAA Policy Manual, will be handled in accordance with this Policy Manual and no patient, personal representative, or workforce member will be retaliated against in any way for:

    A. Filing a complaint with the Privacy Officer or with the Secretary of Health and Human Services (Office for Civil Rights) pursuant to Section 13 of this Policy Manual.
    B. Testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing related to the Privacy Rule.
    C. Opposing any act or practice that is unlawful under the HIPAA Privacy Rule,

provided the person has a good faith belief that the practice opposed is unlawful, and the manner of the opposition is reasonable and does not involve a disclosure of PHI made in violation of the HIPAA Privacy Rule.

2. Workforce members are encouraged to contact the Privacy Officer for clarification in the event of confusion or questions concerning any part of this Policy Manual.
3. workforce members are encouraged to and will immediately report, in good faith, to the SCHD Privacy Officer any knowledge of a violation of this Policy Manual by a member of the SCHD workforce or by a Business Associate, or a violation of this policy of non-retaliation and non-waiver of rights.
4. If SCHD receives information that this policy may have been violated, the Privacy Officer will promptly investigate the report of retaliation and will consult with the County legal counsel regarding the matter as necessary.
5. Any workforce member found to have violated this policy will be sanctioned according to the provisions of Section 15 of this Manual and consistent with the workforce policies.

Sampson County Health Department
Section 15: Sanctions for Violations of Privacy; Exceptions to Sanctions

Purpose:

To ensure all Sampson County Health Department (SCHD) workforce members read and understand HIPAA policies and procedures and the associated consequences of any violations whether intentional or unintentional.

To ensure SCHD patients' protected health information (PHI) is kept confidential.

To provide guidance or immediate mitigation of any breach of privacy.

Policy:

Sampson County Health Department (SCHD) will apply appropriate sanctions against any member of the workforce who fails to comply with the policies and procedures in this Policy Manual or the requirements of the Privacy Rule. Sanctions will not be imposed, however, under certain circumstances described in this Policy.

Definitions:

This Manual has a Glossary of Terms that explains terms used in the Manual – refer to the Appendix, Attachment A.

Applicable Laws, Rules & Regulations:

USC Public Law 104-191: Health Insurance Portability & Accountability Act (HIPAA) of 1996.
45 CFR, Part § 164.502 (j).
45 CFR, Part § 164.530 (e) & (g) (2).

Responsible Persons:

Sampson County Health Department workforce

Procedures:

General Sanctions Policy:

1. SCHD will receive patient complaints regarding the agency's compliance with the Privacy Policies and Procedures or with the Privacy Rule; SCHD may learn of non-compliance issues through allegations of violations received internally from workforce members.
2. Such complaints will be handled in accordance with Section 13 of this Manual.
3. Workforce members are encouraged to make the Privacy Officer aware of any concerns regarding compliance with SCHD's Privacy Policies or with the Privacy Rule. Any

allegations of noncompliance are to be made in good faith, and in accordance with this Manual.

4. All allegations of a violation by a workforce member of a provision of this Policy Manual will be investigated.
5. Appropriate disciplinary action will be taken whenever it is determined that a workforce member committed a significant violation of this Policy Manual or the Privacy Rule.
6. The established disciplinary procedures and processes are applicable to all workforce members as defined in the glossary of terms.
7. The determination of the disciplinary measures to be imposed will be made on a case-specific basis, appropriate to the nature of the violation, and in accordance with workforce policies. The factors to consider may include:

    A. The severity of the violation.
    B. Whether the violation was intentional or unintentional.
    C. Whether there has been a pattern of noncompliance by the workforce member.

8. Disciplinary actions may include:

    A. Counseling
    B. Written warning
    C. Suspension without pay
    D. Dismissal

9. Per Section 12 of this HIPAA Manual, SCHD has procedures in place requiring the workforce members to:

    A. Receive HIPAA training upon hire and annually to ensure and understanding of federal and state HIPAA laws, rules and regulations.
    B. Review and become familiar with this Manual's privacy policies and procedures to ensure an understanding of expectations regarding PHI, privacy and that noncompliance could result in sanctions.
    C. Such training will include the specific requirements regarding impermissible disclosures.

10. The Privacy Officer will be responsible for documenting all sanctions and disciplinary action resulting from a violation.

<u>Exceptions to Sanctions:</u>

1. Sanctions will not apply to a member of the workforce with respect to activities, where the specific requirements for each type of activity or disclosure is met.
2. Actions taken in pursuit of compliance with the Privacy Rule
3. SCHD will not intimidate, threaten, coerce, discriminate against or take other retaliatory action against workforce members or others who:

    A. File a complaint with the Secretary of Health & Human Services, or the Office

for Civil Rights.

B. Testify, assist or participate in an investigation or a compliance review, proceeding or hearing related to OCR's enforcement of the Privacy Rule.

C. Oppose any act or practice made unlawful by the Privacy Rule, provided the person has a good faith belief that the act or Practice is unlawful, and the manner of the opposition is reasonable and does not involve disclosures of PHI in violation of the Privacy Rule.

Implementation of Policy:

1. Violations of the HIPAA Privacy and Security Policy include, but are not limited to:

   A. Accessing PHI date that you do not need in order to perform the work functions.
   B. Discussing confidential information with an unauthorized individual.
   C. Failing/refuse to cooperate with an investigation by the division/facility Privacy and Security officer.
   D. Copying PHI with authorization.
   E. Unauthorized disclosure or use of PHI.
   F. Unpermitted use of another person's computer access in order to obtain PHI.
   G. Obtaining PHI under false pretenses.
   H. Using and/or disclosing PHI for commercial gain, advantage or malicious harm.
   I. Retaining PHI for commercial gain, advantage or malicious harm.

2. Violations of the HIPAA privacy and security policy may be considered unacceptable personal conduct as defined in the county resolutions and may result in disciplinary action up to and including immediate dismissal.
3. Violations my also carry federal civil and/or criminal penalties, and state criminal penalties.

Whistleblowers:

SCHD will not impose sanctions or otherwise retaliate against a member of the workforce or a Business Associate of SCHD who discloses PHI in the following circumstances:

1. The individual believes that the conduct at issue (which requires the disclosure of PHI in order for the individual to report the conduct) is unlawful or otherwise violates professional or clinical standards, or that the care, services or conditions provided by SCHD potentially endangers one or more patients, workers or the public
2. AND if the disclosure is made to one of the following:

   A. A health oversight agency or public health authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions of the Practice.
   B. An appropriate health care accreditation organization for the purpose of reporting the allegation of misconduct or failure to meet professional standards or misconduct by the Practice.

C. An attorney retained by or on behalf of the member of the workforce or Business Associate for the purpose of determining the person's legal options and/or obligations with regard to the agency's conduct.

Victims of Crime:

SCHD will not impose sanctions or otherwise retaliate against a member of the workforce who is the victim of a criminal act and discloses PHI related to the crime, provided that:

1. The disclosure is to a law enforcement official;
2. The PHI disclosed is about the suspected perpetrator of the criminal act; **and**
3. The PHI disclosed is limited to the following information:

A. Name and address;
B. Date and place of birth;
C. Social security number;
D. ABO blood type and Rh factor;
E. Type of injury;
F. Date and time of treatment;
G. Date and time of death, if applicable; and
H. A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair, scars, and tattoos.

Sampson County Health Department
Section 16: Communication by Texting, Appointment Card, Phone Call & Letter

Purpose:

To provide guidance regarding the use of text messaging between health department staff and clients

To provide guidance regarding the use of appointment cards during correspondence with health department clients

To provide guidance regarding the use of telephone calls and/or messages during correspondence with health department clients

To provide guidance regarding the use of letters for correspondence with health department clients

Policy:

It is the policy of the Sampson County Health Department (SCHD) to ensure compliance with the Health Information Portability and Accountability Act (HIPAA) of 1996 to include appropriate use of correspondence between SCHD staff and clients. This policy is intended to provide guidance to staff to ensure correspondence meets all HIPAA guidance and expectations regarding the use of test messaging, appointment cards and return addresses.

Definitions:

HIPAA: The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, that includes Administrative Simplification provisions requiring HHS to adopt national standards for electronic health care transactions and code sets, unique health identifiers, and security; provides mandated protections for individually identifiable health information.

HHS published a final Privacy Rule in December 2000, which was later modified in August 2002. This Rule set national standards for the protection of individually identifiable health information by three types of covered entities: health plans, health care clearinghouses, and health care providers who conduct the standard health care transactions electronically. Compliance with the Privacy Rule was required as of April 14, 2003 (April 14, 2004, for small health plans).

HHS published a final Security Rule in February 2003. This Rule sets national standards for protecting the confidentiality, integrity, and availability of electronic protected health information. Compliance with the Security Rule was required as of April 20, 2005 (April 20, 2006 for small health plans). Source: www.hhs.gov.

Applicable Law, Rules & Regulations:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Responsible Person(s):

All staff

Procedures:

Texting:

1. Texting between staff and clients is not recommended and should only be used on an as needed basis. This may include communication between outreach staff and clients.
2. Texting communication can NOT contain any personal identifying information regarding the client. This includes, but is not limited to:

    A. Date of Birth
    B. Social Security Number
    C. Medical Record Number
    D. Any other personal medical information that is unique to the individual

3. Client confidentiality is to be protected at all times.
4. Staff is to confirm with the client that they wish to communicate via texting and document in the client's record.
5. Texting may ONLY be done on work cell phones, never on personal phones.
6. The message will be deleted from the phone after it is sent.
7. Work cell phones used for texting must have a password and/or PIN and be used when the phone is not in use.
8. Any lost/stolen work phone is to be reported to the health director immediately.
9. Communication can NOT include specific information. Specific organization names, program names or the reason for the contact are not to be used during communication.
10. Communication must be general and contain general information, such as the name of the person texting/calling, a number to call back, the date/time of an appointment. See Appendix: Attachment 2.
11. All staff is to be aware that cell phone conversations and text messages are kept in servers for unknown lengths of time. Cell phone companies are NOT subject to HIPAA.
12. Information may also be accessed by law enforcement without cooperation from SCHD.

Appointment Cards:

1. Appointment cards must meet HIPAA information requirements and should only include the minimal information necessary to ensure correct communication. This may include:

    A. Name of the Agency/Phone Number
    B. Name of the Client

C. Date of Appointment
D. Time of Appointment

2. Appointment cards may NOT contain the reason for the appointment, such as STD Clinic or FP Clinic.
3. Mailed appointment cards should be fold-over or in envelopes rather than post cards to help ensure confidentiality.

Phone Calls/Phone Messages:

1. Phone calls/messages must meet HIPAA information requirements and should only include the minimal information necessary to ensure correct communication. This may include:

   A. Name of the Agency/Phone Number
   B. Date of Appointment
   C. Time of Appointment
      OR
   D. Message to contact provider

2. A message may be left with a family member or other person who answers the phone when the patient is not home. The Privacy Rule allows the disclosure of limited information. This may include:

   A. Name of Agency/Phone Number
   B. Message to contact provider

Letters:

1. All letters MUST be sealed to ensure privacy.
2. Return addresses on SCHD business envelopes are permissible under HIPAA.
3. Minimum information is to be used on the return address. This includes:

   A. Name of the agency
   B. Street/Mailing Address
   C. City
   D. State
   E. Zip Code
   F. The Number Code of the program/clinic for mail billing purposes – see Appendix Attachment 4.

3. The specific name of the program/clinic can NOT be listed on the envelope.

Confidential Communications:

If a patient has requested communication in a confidential manner, such as by alternative means (i.e., another phone number or address) or at an alternative location, the agency must accommodate the request.

References:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA).
Sampson County Health Department Administrative Manual
Attachment H: Guidance from Frances Q. Taylor, NC DHHS HIPAA Liaison

References:

USC Public Law 104-191: Health Insurance Portability & Accountability Act (HIPAA) of 1996.
45 CFR, Part § 160, 162 & 164
North Carolina General Statute: §8-53.
North Carolina General Statute: §8-53.13.
North Carolina General Statute: §130A-12.
North Carolina General Statute: §130A-143.
Sampson County Health Department Information Security Policy
Sampson County Electronics Policy
Sampson County Health Department Electronic Health Records Policy

Sampson County Child Fatality Prevention Team

2017 Annual Report

County: **Sampson County Health Department**
Contact Person: **Wanda Robinson, RN**
Health Director
Contact Number: **910-592-1131, ext. 4971**
Date of Report: **August 1, 2018**

I. Introduction:

Sampson County is required to establish and maintain a Child Fatality Prevention Team to review child fatalities in our community. The teams are established under North Carolina G.S. § 7B-1400 which states "…it is the intent of the General Assembly, through this article, to establish…local teams … in G.S. § 7B-1406. The purpose of the system is to assess the records of ... all deaths of children in North Carolina from birth to age 18…" The purpose of the Child Fatality Prevention Team is to identify areas for improvement and to recommend changes that would promote the safety and well-being of children. The team was initiated in June 1995 and continues to meet on a bi-monthly basis. The team reviewed 8 child fatalities between January 1, 2017 and December 31st, 2017. This was a significant decrease from the previous year. Findings related to these fatalities and the recommendations are found within this report.

II. Team Activities and Recommendations:

The team met on a bi-monthly schedule starting on January 1, 2017. The team, under the direction of the Sampson County Health Director and the Social Services Director and held joint meetings for the County Community Child Protection Team and the Child Fatality Prevention Team.

III. Sampson County Child Fatality Prevention Team Statistical Information:

A. Case Review Process. The purpose of the review is to adequately assess the circumstances surrounding the death of a child. This is done by examining information from agencies that had provided services to the families. The state legislature passed legislation authorizing access of local teams to all medical records, hospital records, and records

maintained by the state, any county or any local agency as necessary to fulfill the team's responsibility to review a child fatality (G.S.§ 143-578).

Cases are identified and recommended for review by the state Child Fatality Prevention Team Coordinator. All team members are alerted and requested to bring information from their agencies to the team meetings. Other professionals known to have involvement with a family are also invited to the case review meeting. Members of the team are reminded and sign confidentiality statements concerning discussion of the cases. Circumstances surrounding the child's death and available information about the families are discussed. Family members are not contacted during this process. System changes are recommended as deficiencies are identified through case review.

B. Type and number of fatalities reviewed (CY-2017):

Child Death by Cases (Cause of Death)	**# Reviewed**
Birth Defects	0
Natural Conditions	0
Perinatal Conditions	1
Illnesses	1
Unintentional Injuries	
Homicide	1
Accidents	4
Other	1
Total	**8**

Child Death by Age	
Infant	2
1-4	2
5-9	1
10-14	0
15-17	3
Total	**8**

IV. Analysis and Recommendations:

A. Trends Identified:

- The death rate decreased substantially for infants; the primary cause

was due to congential birth defects.

- There are no reports of SIDS deaths for the past four years.
- Unintentional injuries increased due to accidents this year. Incidents for included deaths due to single car accidents, children in two collisions involving head on collisions, it is questionable if safety seats were used.

  One accident was crushing head trauma due to machine equipment failure.
- There was one case of death due questionable Benadryl overdose.

B. Recommendations:

Accidents

- Need to develop and conduct public awareness on the importance of safe driving especially on the back roads of the county.
- Safe use of heavy equipment

Drug Overdose

- Public awareness on the usage of certain drugs for children under 2 years of age. Specify the dangers of using over the counter drugs and follow instructions for usage as described in the product label.
- Educate on the signs and symptoms of overdose for children
- Medication Safety for children

Car Seat Safety

- Investigate the availability of safety seats in the county.
- Develop listing of programs and guidelines for each agency.
- Education for community on the importance of car seats and how to access the system.
- Provide public awareness and education on the importance car seats by law enforcement, local agencies, providers, health department outreach services and health fairs.
- Review and seek legislature that impose tougher enforcement of laws and regulations for seat belts.
- Continue to stress the importance of safety belt or appropriate car seat safety for all age groups.

V. Training Needs Identified:

Training is always needed due to CFPT committee members and staff turnover. This will be an ongoing process.

VI. Conclusions:

The team will continue to review and effectively maintain a system's focus. The process has been effective and will continue to be evaluated to ensure quality

reviews. The is to continue to meet jointly with the Child Protection Prevention Team.

Child Fatality Prevention Team
Type and Number of Fatalities

Type and Number of Fatalities Reviewed	CY-2017
Birth Defects	0
Natural Conditions	0
Perinatal Conditions	1
Illnesses	1
Unintentional Injuries:	
Accidents	4
Homicide	1
Other	1
Total	**8**

Definitions:

1. Perinatal Conditions: Preterm infant
2. Unintentional Injuries:
    a. Motor Vehicle accident- Single car crash (16 year old), Car occupant in head on collision (5 year old), car crash-child (2 year old), contact with other machinery-crushing blunt force to the head (16 year old)
3. Homicide: Assault with firearm discharge
4. Other: Unspecified-(6 months) questionable Benadryl overdose

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Addendums

SAMPSON COUNTY HEALTH DEPARTMENT
Appointments Policy

Manual: SCHD Administrative Manual	Applicable Signatures/Title:
Title: Appointments Policy	Program Coordinator/Specialist: N/A
☐ Program Policy: _____Program	Supervisor: N/A
☐ Program Procedure: _____Program	Director of Nursing: Vacant
X Management/Department-wide Policy	Medical Director: Dr. Allyn Dambeck
☐ Personnel Policy	Health Director: Wanda Robinson
☐ Fiscal Policy	Board of Health Chair: Jacqueline Howard
Distributed to: All Personnel	Effective Date: 10/02/2018
	Supersedes: 10/02/2017

Purpose:

The purpose of this policy is to increase compliance for clinical services and assure adequate follow-up of missed appointments for the health department services.

Policy:

The Sampson County Health Department recognizes the importance of providing and maintaining an appointments system that provides a system for clients and staff to be able to provide scheduled care and a means of missed appointments follow-up.

Responsible Person(s):

All clinical and WIC personnel

Procedures:

1. The Appointments Clerk will maintain a central appointments system in CureMD for all programs with the exception of WIC. Clients with appointments in CureMD will be tracked using the CureMD tracking features.
2. The WIC staff will maintain a WIC appointments system for their clients in Crossroads.

Scheduling Appointments:

The Appointments Staff will:

1. Schedule appointments for all clients who call or walk in for appointments.
2. If a client walks in with a problem and there are no available appointment slots, the Front Desk will notify the Nursing Director. If the Nursing Director is unavailable, will notify the Clinic Manager or Charge Nurse to assist with appointment scheduling.

3. Place telephone reminder calls during the morning of two (2) business days prior to scheduled appointments.
4. Recall Schedule: Enter all clients that need annual or long-range follow up on the Saturday Recall Schedule, an appointment schedule created for the first Saturday of each month to allow Appointment Staff to enter information for clients that need annual or long-range appointments. Appointment staff will check this schedule on the Monday following the first Saturday of each month and call clients to schedule follow-up appointments. Appointments to be entered into this schedule will include all appointments needed for three (3) months or greater with the exception of return appointments for Depo injections; Depo clients will be given a return appointment.

Missed Appointments:

1. Missed appointment follow-up:

   A. The initial contact for a missed appointment is to be made by a phone call unless seeking confidential services. This can be done by either speaking directly to the client or leaving a voice mail for the client.
   B. If not confidential and unable to contact the client by phone with first call, staff will make a second phone call. If unable to contact with second call or if the number is disconnected, a letter will be mailed.

2. Confidential Clients:

   A. If clients are seeking confidential services, they will be requested to provide a minimum of two (2) emergency contact numbers. An attempt will be made to contact clients though their emergency contact numbers and no mail will be sent unless a confidential contact address is given by the client.
   B. If the Appointment Clerk is unable to contact clients through the emergency contact numbers or no response if a letter is mailed to a confidential address, no further attempt will be made to contact them unless it is required by State Law for certain results or there is evidence that not notifying the client could result in major illness and/or death. Refer to Missed Appointment for Abnormal Results below.
   C. The Program Coordinator will be responsible for contacting the client under these circumstances. Refer to Missed Appointment for Abnormal Results below.

Missed Appointments Follow-up for Appointments Staff:

1. Staff will document the missed appointment contacts and follow-up on a Blank SOAP Note in CureMD – see the "Documentation" Section below.

   A. The Appointments Staff will review the missed appointments in CureMD and send a task to the Family Planning, Maternal Heath, STD, TB/CD, BCCCP or Adult Health Program Coordinators the charts of those clients who missed their appointments and were scheduled for problems and/or follow-up. The

Coordinators will be responsible for ensuring the follow-up with these clients. Refer to Missed Appointment for Abnormal Results below

B. The Appointments Staff will review the missed appointments in CureMD and send a task to the Child Health Coordinator for any Child Health all clients less than two (2) years old.

C. Appointments Staff will document missed appointments for all other Family Planning, Child Health and TB/CD clients. The Appointments Staff will document in those clients' records the fact that the appointment was missed, the type of follow-up contact that was performed and the date of any rescheduled appointments.

D. For Family Planning clients, the Appointments Staff will:

1. Provide one contact for missed appointments for contraceptive refills and depo injections.
2. Provide one contact for missed appointments for annual FP annual exams.

2. STD clients that schedule an appointment for a screening and miss their appointments will not need missed appointment documentation in their record.
3. Program Coordinators will review the information, document if the client needs to be rescheduled and send a Task to the Appointments Staff for scheduling – refer to program follow-up guidance below.
4. New Clients/New Services: New clients and clients scheduling appointments for new services that miss those appointments will not need documentation. For New MH clients:

A. For the first missed appointment, the staff will reschedule the appointment for five (5) working days and send the client a letter.

B. For the second missed appointment, they will notify the MH Coordinator who will follow-up with a 10 day letter.

C. A home visit may be attempted by health department staff per assignment by the Nursing Director.

D. All documentation regarding follow-up by appointment staff will be done on a Blank SOAP Note. Program Coordinators will use the Provider Note.

5. Clients requesting other services, such as TB Skin testing, pregnancy testing, BCCCP, Adult Health, Work/Sports/School physicals, or immunizations will not need documentation with the exception of MH clients.
6. The Program Coordinators will be responsible for any follow-up letters that are needed per program requirements – see Documentation below.

Maternal Health (MH) Client Missed Appointment Follow-up:

The MH Coordinator will be responsible for ensuring the follow-up of MH clients who miss appointments:

1. First missed appointment: The Appointment Clerk will contact the client by phone call or letter – see Missed Appointments above.

2. If able to contact the client by phone, the Appointment Clerk will reschedule the appointment within two (2) business days.
3. If unable to contact client by phone, the Appointment Clerk will reschedule the appointment for five (5) business days from date and send client the rescheduled appointment letter.
4. The Appointment Clerk will document the information in the record and send a Task to the Maternal Health Coordinator for review.
5. Second missed appointment: See 2-4 above. The Appointment Clerk will send a Task to the MH Coordinator who will:

    A. Complete an OB Risk Screening Form and send to OBCM
    B. As the third contact, mail a 10-Day Missed Appointment Letter to the client.

6. Missed Postpartum Appointments:

    A. The Appointment Clerk will document missed appointment.
    B. The Appointment Clerk will reschedule the appointment for five (5) working days, send client letter and send a CureMD Task Note to the MH Coordinator.
    C. The MH Coordinator will follow-up with OBCM if applicable and OBCM will follow-up as indicated by CMIS guidelines.

Diabetes Self-Management Program (DSMP) Client Missed Appointment Follow-up:

The DSMP Coordinator will be responsible for ensuring the follow-up of DSMP clients that miss appointments. The DSMP Coordinator will review all charts and provide those that need missed appointment follow-up to the Appointment Clerk. The DSMP Coordinator will be responsible for the follow-up and documentation of all other clients.

1. First missed appointment: The Appointment Staff will contact the client by phone call or letter – see "Missed Appointments" above.
2. If able to contact the client by phone, the Appointment Staff will reschedule the appointment for the next available Diabetes clinic.
3. If unable to contact client by phone, the Appointment Clerk will reschedule the appointment for at least five (5) business days from the missed appointment date in the next available Diabetes clinic and send the client the rescheduled appointment letter.
4. The Appointment Clerk will document the information in the record on a blank SOAP Note and send a Task to the Diabetes Coordinator.
5. Second missed appointment: See 2-4 above.
6. Third missed appointment: The DSMP Coordinator will send a Closure Letter to the client and the client's provider, place copies in Medical Records to be scanned in the client's record and document on the Problem List and Provider Notes.

TB Clinic Client Missed Appointment Follow-up:

The CD Coordinator will be responsible for ensuring the follow-up of certain TB clients who miss appointments:

1. First missed appointment: The Appointment Clerk will contact the client by phone call or letter – see "Missed Appointments" above.
2. If able to contact the client by phone, the Appointment Staff will reschedule the appointment within two (2) business days.
3. If unable to contact client by phone, the Appointment Clerk will reschedule the appointment for five (5) business days from date and send client the rescheduled appointment letter.
4. The Appointment Clerk will document the information in the record and send a Task to the CD/TB Coordinator to review.
5. Second missed appointment: See 2-4 above.
6. Third missed appointment: The CD/TB Coordinator will send a TB Services Closure Letter to LTBI clients, place a copy in Medical Records to be scanned if the letter is not in CureMD and document on the Problem List and in the Provider Notes.
7. The CD Coordinator will follow the NC TB Policy Manual protocol for missed appointments for TB clients with suspected or confirmed TB disease.

STD Clinic Client Treatment/Follow-up Appointments & Missed Appointments:

1. The STD Coordinator will follow North Carolina Communicable Disease Laws and Rules regarding follow-up of certain STD clients and for notifying the Regional HIV/STD Branch office of failure of certain clients to keep appointments.
2. The STD and/or CD Coordinators will be responsible for ensuring the follow-up of all positive STD tests.
3. Clients with positive test results should receive treatment within fourteen (14) calendar days of testing.
4. Due to the short time constraints, the STD Coordinator will be responsible for the follow-up and documentation of follow-up unless specific instructions are given to the Appointments Staff. This is to include the date, type of contact, follow-up and signature of person performing the contact/follow-up.
5. Once notified of a positive result, the Coordinator will:

    A. Identify the client in CureMD and open a Provider Note for documentation.
    B. Document the result in the record to include the Problem List, Patient Banner and in the Provider Note to allow the Appointment Clerk to easily identify a client that needs follow-up
    C. Contact the client and ensure an appointment is scheduled for the client to come in for treatment and/or follow-up.

6. If the client misses the appointment, the Appointment Staff will send a Task to the STD Coordinator to allow the Coordinator to contact the client regarding the missed appointment.

7. The Coordinator will be responsible for ensuring a second appointment is scheduled for the client.
8. If the client misses the second appointment, the STD Coordinator will send the client a STD missed appointment letter that stresses the importance of seeking treatment and/or care. If the letter is not in CureMD, place a copy of the letter in Medical Records to be scanned into the record and document on the Problem List and the Provider Note.
9. The STD Coordinator will contact the Regional HIV/STD/DIS Office regarding clients needing HIV and/or Syphilis follow-up that fail to keep their appointments.

Missed Appointments for Abnormal Findings Follow-Up Part 1:

The following is guidance from the North Carolina DHHS DPH regarding follow-up for abnormal findings and referrals – see Appendix, Attachment A.

NC DHHS DPH Guidance for Follow-up of Abnormal Labs, Pap Tests &Other Abnormal Test Results.

NOTE: *If DPH programmatic guidelines have stricter requirements or more specific abnormal test follow-up guidance, follow program specific guidance.*

1. Follow-up of Abnormal Labs, Pap Smears and other abnormal test results:

   A. Managing abnormal test results effectively is vital to quality patient care.
   B. Failure to follow up on test results can lead to patient harm.

2. Appropriate follow-up measures should be taken to ensure continuity of care for:

   A. Patients who have abnormal test results
   B. Patients who have been referred to other providers
   C. Patient who have missed return appointments for abnormal results

3. Staff will make a minimum of three attempts to notify patients of abnormal Pap test or other abnormal tests results as follows:

   A. Initial Contact:

      1. Initial contact may be made by telephone if the number is available and patient has permitted home contact.
      2. Never text/email abnormal test results
      3. Arrange for any needed re-test, treatments or referral appointments while the client is on the phone.
      4. Send a memo to the client affirming the discussion and instructions.
      5. Make sure the client agrees to any referrals outside of SCHD.

   B. If there is no response to the first contact attempt, the second contact be a regular mailed letter with directions for the patient to contact SCHD for follow-up.

C. If there is no response to the first and second attempt, the third contact is to be a certified or registered letter with directions for the patient to contact SCHD for follow-up.
D. Copies of all letters will be scanned into the client's chart and the Program Coordinator will document that there is a copy of the letter in the record and the date the letter was sent in the Provider Note.

4 The same process listed in #3 above will be used for missed appointments for follow-up.
5. If any letter comes back unopened/undeliverable, the Program Coordinator will document on the Problem List and Provider Note in the medical record.
6. If a letter is sent certified/registered, a copy of the letter, the signed receipt from the US Postal Service and envelop will be scanned into client's medical record.
7. If the patient cannot be contacted by the above measures, a home visit will be made for results that are potentially life threatening. The Nursing Director will be notified and make the arrangements.
8. If after three attempts are made with no response or three follow-up appointments are made and not kept by the patient, the Program Coordinator will document in the chart that the patient is lost to follow-up care.
9. For clients that require referrals for health care beyond what SCHD provides:

A. Assist the client in obtaining an appointment
B. Document all conversations and appointments made in the client's record.
C. Ensure the client agrees to the time and date of the appointment (do not assume that because an appointment is sent to the client that it is acceptable).
D. Confirm with the client that he/she understands the purpose of the referral and agree to date and time.
E. The Program Coordinator will contact the Provider to ensure the client keeps the appointment.

10. Record closed to follow-up:

A. If the client fails to keep three or more scheduled follow-up appointments, SCHD may discharge the client from the follow-up service via certified letter for non-compliance with follow-up care for the medical condition if the Program Coordinator has followed the appropriate follow-up steps – refer to #2 - #7 above.
B. If the client fails to keep the referral appointments 2-3 times, based on the referral provider's policy the client is referred to, SCHD may discharge the client from follow-up referral service via certified letter for non-compliance with follow-up care for the medical condition. Refer to #2 – #7 above.
C. The letter is to state that the client is now responsible for their own care. **SEND THE LETTER CERTIFIED** and keep a copy in the client's record – refer to #5 and #6 above.

Missed Appointments for Abnormal Findings Follow-Up Part 2:

All abnormal labs or findings will be reviewed by the Program Coordinators and/or the

clinic providers who will provide medical record documentation for follow-up.

1. Child Health Services:
   The Child Health Coordinator is responsible for the follow-up of children less than two years old that do not keep their appointments and for any abnormal findings related to Child Health Services according to program policy. For positive STD results - see STD below. Refer to Part 1 above.

2. Maternal Health:
   The Maternal Health Coordinator is responsible for the follow-up of any abnormal findings related to Maternal Health Services according to program policy or a written order by the provider. A home visit and/or letter may be indicated according to program policy. For positive STD results - see STD below. Refer to Part 1 above.

3. Family Planning:
   The Family Planning Coordinator is responsible for the review and follow-up of any abnormal findings related to Family Planning Services according to program policy. For positive STD results - see STD below. Refer to Part 1 above.

4. STD:
   The STD Coordinator is responsible for the review and follow-up of any abnormal findings related to STD services according to program policy. See "STD Clinic Client Missed Appointment Follow-up" above.

   STD Screenings are provided in all health department clinics and testing is done based on program guidelines and screening results. Each Program Coordinator is responsible for ensuring the follow-up, to include treatment if indicated, of their clients and notification is to follow the same guidelines required for the STD Program. See STD Clinic Client Treatment/Follow-up Appointments & Missed Appointments guidance above. This is to be done in collaboration with the STD Coordinator. Refer to Part 1 above.

5. CD/TB Services:
   The CD/TB Coordinator is responsible for the review and follow-up of any abnormal findings related to CD/TB services according to program policies. Refer to the TB Client Missed Appointment Follow-up above. Refer to Part 1 above.

6. BCCCP/Adult Health:
   The BCCCP/AH Coordinator is responsible for the review and follow-up of any abnormal findings related to BCCCP/AH services according to program policies. For positive STD results - see STD above. Refer to Part 1 above.

7. Abnormal Pap Results:
   With the exception of Child Health, all clinic programs may provide Pap testing to clients and will follow the North Carolina Cervical Screening Manual and Sampson County Health Department Pap Screening Manual guidelines. Each Program Coordinator is

responsible for the follow up of all abnormal findings based on these guidelines. All abnormal Pap results will require a minimum of three (3) contacts for missed appointments. For results of Positive HPV, ASC-H, LSIL or higher, the third contact must be by **certified letter** – see "Documentation" below. Refer to Part 1 above.

WIC Appointments:

The WIC Receptionist/Staff will:

1. Schedule appointments for clients who call or walk in for appointments.
2. For Recertification Clients: Contact will be made at least fifteen (15) days prior to the Recertification appointment:

    A. The initial contact for the upcoming appointment is to be made by a phone call. This can be done by either speaking directly to the client or leaving a voice mail for the client.
    B. If unable to contact the client by phone, a letter will be mailed.

3. For Nutritional Assessment Visit for Five Month Old: Contact will be made at least fifteen (15) days prior to the Nutritional Assessment appointment:

    A. The initial contact for the upcoming appointment is to be made by a phone call. This can be done by either speaking directly to the client or leaving a voice mail for the client.
    B. If unable to contact the client by phone, a letter will be mailed.

Rescheduling Missed WIC Appointments:

1. Missed Certification/Recertification for Pregnant Women: Contact will be made within ten (10) days of the missed appointment:

    A. The initial contact for the missed appointment is to be made by a phone call. This can be done by either speaking directly to the client or leaving a voice mail for the client.
    B. If unable to contact the client by phone, a letter will be mailed.
    C. If no response from the client within seven (7) days, a second contact is to be made by phone call. This can be done by either speaking directly to the client or leaving a voice mail for the client.
    D. If unable to contact the client by phone, a letter will be mailed.
    E. If no response from the client within seven (7) days, no further follow-up will be done.

2. Missed Nutritional Assessment, Certification, Recertification & Pickup Appointments:

A. The initial contact for the missed appointment is to be made within ten (10) calendar days by a phone call. This can be done by either speaking directly to the client or leaving a voice mail for the client.
B. If unable to contact the client by phone, a letter will be mailed.
C. If no response from the client within seven (7) calendar days, no further follow-up will be done.

Documentation:

1. All attempts to contact clients will be documented in the record by any person who provides the contact by telephone call, mail, home visit or any other means. Appointment staff will use the Blank SOAP Note; coordinators will use the Problem List and Provider Note.
2. All abnormal findings will be documented on both the Problem List and in the Provider Notes by the Program Coordinator.
3. Letters that are not available in CureMD will be copied and placed in Medical Records to be scanned into the record with documentation on the letter of the date the letter was mailed and the signature of the person mailing the letter. The person mailing the letter will document in the Problem List and the Provider Note regarding the letter being mailed.
4. Certified Letters: Certified letters may be sent for follow-up as needed. See Missed Appointments for Abnormal Findings Follow-Up guidance above. The Program Coordinators will be responsible for the certified letter process, which includes:

    A. Completing the certified letter forms
    B. Placing the letter in the mail room
    C. Placing a copy of the letter in the chart
    D. Placing all receipts in the chart
    E. Placing any returned/unclaimed letters in the chart.

5. Any other returned letters will be placed in Medical Records for scanning.
6. All letters for WIC are computer generated in Crossroads and documented.

Closure to Requested Services/Follow-up for Services:

1. Clients with no specific problems may receive one missed appointment contact based on the type of appointment and, if no response, no further follow-up will occur unless indicated otherwise by program guidelines – see above for specific guidelines.
2. Clients with problems or clients that require follow-up and/or referrals will have their records reviewed by the Program Coordinator for determination of appropriate record follow-up and documentation – ~~see above for specific guidelines.~~ See Missed Appointments for Abnormal Findings Follow-Up guidance above.
3. Clients may re-enter the health department system at any time unless their charts are closed to services due to specific circumstances, such as violence towards staff.
4. Only the Health Director has the authority to close a client record to health department services. This must be done in accordance with North Carolina laws.

Revised/Reviewed: 01/16/2009; 03/13/2010; 02/11/2011; 04/17/2012; 09/05/2013, 10/7/13; 09/2015; 11/2015; 02/2017; 08/2018

SAMPSON COUNTY HEALTH DEPARTMENT
Community Input, Involvement, Collaboration & Partnership Policy & Procedures

Manual: SCHD Administrative Manual	Applicable Signatures/Title:
Title: Sampson County Health Department Community Input, Involvement, Collaboration & Partnership Policy & Procedures	Program Coordinator/Specialist: N/A
□ Program Policy: _____Program	Supervisor: N/A
□ Program Procedure: _____Program	Director of Nursing: Vacant
X Management/Department-wide Policy	Medical Director: Dr. Allyn Dambeck
□ Personnel Policy	Health Director: Wanda Robinson
□ Fiscal Policy	Board of Health Chair: Jacqueline Howard
Distributed to: All Personnel	Effective Date: 10/02/2018
	Supersedes: 10/02/2017

Purpose:

To provide procedures regarding the development of community involvement, collaboration and partnerships to improve the public health and safety of Sampson County residents.

To provide a procedure that assures community input and public participation in the development of goals, objectives and strategies for Sampson County Health Department (SCHD) Programs, the Community Health Assessment – CHA, the State of the County Health report – SOTCH, the Strategic Plan and any other projects and/or programs that depend on community input to develop and maintain goals.

Policy:

Sampson County Health Department (SCHD) recognizes the importance of community involvement, input, collaboration and partnering in the development and maintenance of public health policies and programs to ensure the effectiveness of public health in our community. Input from consumers helps to guide SCHD in partnering with the community to provide needed health services, education and outreach.

When developing strategies to improve the public health and safety of Sampson County, The Sampson County Health Department's policy is to involve community members in developing the Strategic Plan, CHA, SOTCH, education/outreach and any other program plans and projects.

The Sampson County Health Department also relies on the community to provide input for the development and dissemination of public health data in Sampson County.

Procedures are used to develop strategies to involve community organizations, agencies, groups and the public in the collaborations and partnerships.

Responsible Persons:

Health Department Personnel
Sampson County Partners for Healthy Carolinians Advisory Group
Academic Abundance Community Advisory Council

Procedures:

1. The Sampson County Health Department (SCHD) seeks opportunities to collaborate with community partners, including other health care providers.
2. As a part of seeking community input and collaboration with the community, SCHD often collaborates with two groups – the Sampson County Partners for Healthy Carolinians Advisory Group) and the Academic Abundance Community Advisory Council.

    A. Both groups are comprised of female and male members that represent a variety of races, geographical locations, professions, incomes and beliefs within the county.
    B. The group members are health services consumers that include public health, such as adult health, communicable disease, child health, immunizations, family planning, prenatal, WIC, BCCCP/WW, environmental health, and/or other services and can therefore provide needed involvement, input and feedback at any time for SCHD programs and needs from the perspective of a consumer and community resident.
    C. The Healthy Carolinians Community Advisory Group serves as the advisory committee for many of the health department programs, such as Maternal Child Health, Child Health and the Family Planning Programs – see Appendix.
    D. Health Department personnel are responsible for scheduling meetings and notifying the group of the meeting places, dates and times.

3. SCHD staff are involved in local, regional, and state partnership initiatives as relative to their disciplines and program areas.
4. SCHD staff initiates collaboration with community partners.
5. SCHD works with community partners to reduce barriers to access to care, to strengthen existing services and programs, to develop new services and programs, and to share resources.
6. SCHD staff serves on community boards and coalitions.
7. SCHD staff collaborates with each other through service on in-house committees.
8. Community partners are kept informed about Health Department services and programs.
9. Community input is sought when SCHD initiates projects concerning the health and well-being of the community.

10. The Sampson County Health Board of Health and the Health Department use community input in the development and dissemination of public health data in Sampson County.
11. Community input and information is used in the development of the Sampson County Community Health Assessment (CHA) and the State of the County Health Report (SOTCH)
12. CHA and SOTCH information is used to develop the Health Department's Strategic Plan.

    A. The plan is updated annually.
    B. The plan includes:

        1) A review and analysis of factors influencing the health department's ability to improve the community's health
        2) Local health status data and information to set goals and objectives
        3) Community input where applicable
        4) Desired outcomes for each element
        5) Priorities for the agency and
        6) Community collaborations to implement activities

APPENDIX

Family Planning Community Advisory Assistance:

1. Both the Academic Abundance CAC and the Healthy Carolinians Advisory Group serve as advisory groups for the Family Planning Program.
2. Academic Abundance CAC: serves as a resource for discussion of data, consumer input, methods, potential/realized projects and other information as needed.
3. Healthy Carolinians Advisory Group: The Partnership has long recognized teen pregnancy as a major public health concern. The Group meets monthly to discuss and provide input, guidance and recommendations regarding ways to reduce teen pregnancy:

    A. Assists with the planning and providing the Annual Teen Health Fair
    B. Assists with Health Fairs and Community Presentations
    C. Members provide family planning related newspaper articles
    D. Assist with providing and/or updating the Health Carolinians website and Facebook page.
    E. Assists with data collection for the SOTCH and CHA
    F. Provides recommendations for implementation of strategies to reduce teen pregnancies, unwanted pregnancies and spacing of pregnancies.
    G. Assists with providing input, recommendations, discussions, etc. of any other family planning related concerns as needed.

Maternal & Child Health Advisory Group Programs:

1. The Healthy Carolinians Advisory Group serves as the community action group for prenatal, family planning and child health related programs.
2. The goal of the Group is to promote activities that will lead to improved birth outcomes. This may be accomplished by reviewing data and offering recommendations including, but not limited to:

   A. Promotion of prenatal care; early, regular, routine prenatal care; use of 17P; tobacco cessation
   B. Promotion of Family Planning services: reproductive life planning; adequate spacing of pregnancies; use of long-term contraceptives; reducing teen pregnancy; reducing repeat teen pregnancy.
   C. Promotion of child health care: Safe Sleep; regular, frequent routine provider visits; regular/recommendation follow-up of medical conditions/concerns, such as asthma, premature birth, birth defects, etc.
   D. Any other guidance discovered with review of data and/or other information.

3. The Group meets monthly and reviews data and information from federal, state and local sources as needed for community analysis for planning and implementation.
4. The Group gathers and reviews the data and information to provide recommendations regarding information to include on reports.

SAMPSON COUNTY HEALTH DEPARTMENT
Confidentiality Policy & Procedures

Manual: SCHD Administrative Manual	Applicable Signatures/Title:
Title: Sampson County Health Department Confidentiality Policy & Procedures	Program Coordinator/Specialist: N/A
☐ Program Policy: _____Program	Supervisor: N/A
☐ Program Procedure: _____Program	Director of Nursing: Vacant
X Management/Department-wide Policy	Medical Director: Dr. Allyn Dambeck
☐ Personnel Policy	Health Director: Wanda Robinson
☐ Fiscal Policy	Board of Health Chair: N/A
Distributed to: All Personnel	Effective Date: 10/02/2018
	Supersedes: 10/02/2017

Purpose:

The purpose of this document is to provide guidance to all members of the Sampson County Health Department (SCHD) workforce as related to the confidentiality of patient information and medical records. The scope of this document applies to all members of the SCHD workforce and all business associates.

Policy:

SCHD's policy regarding the confidentiality of client information and medical records is in accordance with federal and state laws that address confidentiality. See Legal Authority.

Legal Authority:

1. Federal Health Insurance Portability and Accountability Act, 1996 (HIPAA)
2. North Carolina General Statute G.S. 130A-12
3. North Carolina General Statute G.S. 130A-143
4. North Carolina General Statute G.S. 130A-212
5. 42 CFR 59.11: Title X
6. Trafficking Victims Protection Act of 2000

Definitions:

Client: Any person who receives any type of services provided by or for health department personnel. Clients may include, but not be limited to: paying clients; SCHD staff; volunteers; or any other person provided health department services.

Personnel: In the context of this document, refers to any person who provides any type of services to or for a client. This includes SCHD employees, students, volunteers,

contract workers, sub-contractors, vendors, business associates and any other person who may have access to client information for any purpose.

Protected Health Information (PHI): PHI is any information about an individual's current, past, or future physical or mental health that is attached to demographic information and that can identify that person. This information includes: Name; Address; Telephone Number; Fax Number: Driver's License Number; Social Security Number; Client/Patient Identification and/or Account Number; Health Insurance Plan Identification Number

Procedures:

Protected Health Information (PHI) Overview:

1. All Protected Health Information (PHI) is strictly confidential. Client information will only be shared on a "need to know" basis. It is the responsibility of all personnel to protect client information.
2. Personnel will be responsible for ensuring that client information is kept in a safe, secure environment.
3. Only persons with legal or authorized consent may have access to client information.
4. Client information may only be viewed and/or discussed on a need to know basis by personnel providing services to or for the client.

Client Services:

1. SCHD follows the guidelines as set forth in the 1974 Federal Privacy Act, the 1996 Health Insurance Portability and Accountability Act and other applicable federal and state laws.
2. No information obtained by personnel about individuals receiving services may be disclosed without the individual's written consent, except as required by law or as necessary to provide services to the individual, with appropriate safeguards for confidentiality. See Release of Information below and refer to SCHD Medical Records/Electronic Health Record (EHR) Policy.
3. A confidentiality statement is placed in all client charts.

Voluntary Participation:

1. All client services are provided on a voluntary basis except as required by law.
2. Clients may request one or more individual program services and may qualify based on each individual program's guidelines.
3. Participation in each program is voluntary and is not a prerequisite to eligibility for other programs, except as required by individual program requirements.
4. Every effort is made to ensure client confidentiality and privacy when transitioning from program to program.

Emergency Contact Information:

1. To ensure proper notification in the event of an emergency or for abnormal findings, all clients are requested to provide a personal contact phone number and a mailing address in order to receive any necessary correspondence.
2. Clients are also requested to provide additional emergency contact information to include a minimum of two (2) contact persons with phone numbers.

No Contact Confidentiality Request:

1. Clients may request no contact confidential services that include no personal phone and/or home address contact.
2. In the event this request is made, the client must provide emergency contact information for two (2) emergency contacts that includes names and phone numbers for the contacts in the event that notification is necessary due to emergency situations or abnormal findings.

Emergency Information:

1. SCHD recognizes that emergencies occur with individuals; in the event information is requested regarding a client during an emergency, only the minimum amount of information that is necessary to provide care for the client will be released.
2. Released information may include: client identifying information to ensure correct identification; last vital signs information, if known; any signs/symptoms related to the emergency event if applicable; any other information that may affect the care of the individual during the emergency.

Civil Rights:

1. To ensure client confidentiality, SCHD follows Title VI of the 1964 Civil Rights Act and provides services to clients without regards to race, color, gender, national origin, marriage status, number of pregnancies or LGBTQ.
2. This includes the provision of confidential interpreting services to clients as needed. To ensure client confidentiality and privacy, only staff employed by SCHD or the Medical Language Line are used to provide interpreting services to clients as needed.
3. The Ubi-Duo will be used in a confidential manner for clients that are deaf/hard to hearting/mute.

Personnel:

1. All information regarding personnel is considered confidential.
2. This includes information on services provided to health department personnel that is placed in the personnel member's medical record and/or any information placed in the personnel member's personnel record.

3. Only the personnel member's supervisor, department supervisor, administrative support supervisor, health director and county administration office may have access as needed to any information in the personnel record.
4. The Administrative Support Supervisor is responsible for ensuring personnel records are kept in a secured, locked area and are only available to approved personnel.
5. The Administrative Support Supervisor is responsible for obtaining copies of required licenses for specific personnel prior to hire and placing them in the individual's personnel file to ensure personnel confidentiality and privacy.
6. All staff receives training regarding client confidentiality upon hire and annually.

Adolescents/Minors:

1. North Carolina Law provides confidentiality to adolescents seeking certain services to include Family Planning, Immunizations, Communicable Disease prevention to include STDs.
2. Adolescents must be assured that services are confidential and, if follow-up is necessary, every attempt will be made to assure the privacy of the individual.
3. Only persons with legal or authorized consent may have access to client information. Parents may not have access to this information except under specific guidelines. Information may be accessed when:

    A. Specific authorization by written consent of the client or those authorized to give consent for the client is given
    B. Personnel providing appropriate medical care to the client, except as described in NC G.S. 130A-143, needs access to information
    C. Necessary for protection of the public's health as provided by the rules of the Health Services Commission
    D. Requested by law enforcement, court order or duly authorized subpoena

4. For Family Planning services, staff is to encourage the adolescent to include family participation in seeking family planning services and provide counseling to minors on resisting attempts to coerce them into engaging in sexual activities.
5. SCHD may not require written consent of parents or guardians for the provision of services to minors that are covered under the North Carolina General Statutes.
6. SCHD may not notify parents or guardians before or after a minor has requested and received Title X family planning services.

Test Results:

Test results may be given over-the-phone or in person with the proper identifying information – see SCHD ~~Medical Records/~~Electronic Health Record (EHR) Policy.

Abnormal Findings/Test Results:

1. Clients will be notified of any abnormal findings.

2. SCHD staff will review client information to ensure the client has not requested no contact confidentiality.
3. Staff will use the contact information provided by the client for notification.
4. To ensure appropriate client identification and notification, clients must report to SCHD.
5. The notifying staff member will make arrangements to notify the client and inform the client of the need to report to SCHD for follow-up.

Follow-Up/Referrals:

1. Clients with abnormal clinical and/or laboratory testing findings may require additional testing and/or follow-up by other providers.
2. Every effort will be made to protect client confidentiality and privacy.
3. Only information necessary for follow-up of the abnormal findings will be provided to the referral provider to ensure client confidentiality.
4. Consent will be obtained for follow-up except where exempt by law.
5. The client will be counseled regarding confidentiality and responsibility for follow-up to ensure maintenance of confidentiality and privacy.

Medical Records:

~~All paper client medical records are confidential and are kept in a locked secured area that is accessible only to staff as needed. See SCHD Medical Records/EHR Policy. To help ensure client confidentiality and privacy, medical records must be:~~

~~1. Complete, legible and accurate, including documentation of telephone encounters of a clinical nature~~
~~2. Signed by the clinician and other appropriately trained health professionals making entries, including name, title and date~~
~~3. Readily accessible~~
~~4. Systematically organized to facilitate prompt retrieval and compilation of information~~
~~5. Confidential~~
~~6. Safeguarded against loss or use by unauthorized persons~~
~~7. Secured by lock when not in use~~
~~8. Available upon request to the client~~

~~To ensure confidentiality and privacy, all client records must contain:~~

~~1. Sufficient information to correctly identify each client~~
~~2. Indicate when, where and how each client may be contacted~~
~~3. Provide problem lists, allergies, clinical impressions, diagnoses, treatments, plans of care and any needed follow-ups~~
~~4. Identify clients who have requested confidential services.~~

1. All electronic health records are confidential and computers containing client information are kept secure and away from the vision of other clients and staff. See the SCHD EHR Policy, the SCHD Computer Use Policy and the SCHD Information Sharing Policy.
2. Remaining paper records are kept in a locked secured area that is accessible only to staff as needed. See the SCHD Medical EHR Policy.
3. To help ensure client confidentiality and privacy, medical records must:

   A. Contain sufficient information to correctly identify each client.
   B. Indicate when, where and how each client may be contacted.
   C. Identify clients who have requested confidential services.
   D. Be kept confidential.
   E. Safeguarded against loss or use by unauthorized persons
   F. Kept secure when not in use
   G. Maintain all sections of the EHR in a secure manner so that it is not available except to staff authorized to view the information.

Release of Information:

1. All client information is confidential and a written consent must be obtained from the client for release of any information except as allowed by law or as required law/North Carolina General Statutes, which generally apply to Communicable Disease/STDs include TB, HIV and Syphilis. See SCHD ~~Medical Records/~~EHR Policy.
2. When information is requested, only the specific information related to the written request/referral may be released.
3. Clients transferring to another provider may request a copy or summary of the medical record to expedite continuity of care.

Reporting/Research/Statistical Information:

Information collected for reporting, research, statistical, publications or any other purposes may be disclosed only in summary, statistical, or other form that does not use any type of information to identify specific individuals. See SCHD Research Policy.

Required Reporting:

Regardless of client confidentiality and privacy, SCHD is required by North Carolina Law to report the following to authorities:

1. Child abuse
2. Child molestation
3. Sexual abuse
4. Rape
5. Incest
6. Human trafficking

7. Communicable Diseases, including STDs

Failure to Observe Confidentiality Laws:

Failure to observe confidentiality rules is reason for personnel discipline actions, including immediate dismissal, immediate annulment and/or voiding of vendor contracts and/or a lawsuit.

Confidentiality Agreement:

All personnel are required to sign a confidentiality agreement before being allowed to provide any services to clients and on an annual basis. See the Appendix for the SCHD Confidentiality Agreement.

References:

Federal Health Insurance Portability and Accountability Act, 1996 (HIPAA)
North Carolina General Statute G.S. 130A-12
North Carolina General Statute G.S. 130A-143
North Carolina General Statute G.S. 130A-212
42 CFR 59.11: Title X
Trafficking Victims Protection Act of 2000
http://www.hhs.gov/ocr/privacy/index.html
http://www.ncga.state.nc.us/gascripts/Statutes/StatutesTOC.pl?Chapter=0130A
http://www.sampsonnc.com/personnelres.pdf

SAMPSON COUNTY HEALTH DEPARTMENT
Consumer Complaint Policy & Procedures

Manual: SCHD Administrative Manual	Applicable Signatures/Title:
Title: Sampson County Health Department Consumer Complaint Policy & Procedures	Program Coordinator/Specialist: N/A
☐ Program Policy: _____Program	Supervisor: N/A
☐ Program Procedure: _____Program	Director of Nursing: Vacant
X Management/Department-wide Policy	Medical Director: Dr. Allyn Dambeck
☐ Personnel Policy	Health Director: Wanda Robinson
☐ Fiscal Policy	Board of Health Chair: Jacqueline Howard
Distributed to: All Personnel	Effective Date: 10/02/2018
	Supersedes: 10/02/2017

Purpose:

To provide a reporting system that that allows clients to file complaints/concerns to ensure quality health care and services and to provide documented timely and quality resolution to consumer complaints/concerns. The purpose of this guidance is to ensure:

1. A mechanism is in place to receive consumer complaints.
2. Individuals are informed of their rights to express complaints.
3. Individuals who voice complaints receive an objective review and a timely response without fear of retaliation.
4. Consumers and staff are informed of the agency's mechanism for filing complaints.
5. Staff is trained to receive follow up and document complaints appropriately.
6. The Health Director receives, coordinates, and documents the review of all complaints based on the information received with the complaint.
7. Corrective action to resolve concerns and complaints is planned and implemented.
8. Complaints and their disposition are documented and tracked.

Policy:

~~The Sampson County Health Department recognizes the right of consumers to voice their complaints. Complaints may be against a service, an individual, a situation, a public health law or public health authority. This policy provides a mechanism for the receipt, follow-up and resolution of complaints.~~

The Sampson County Health Department (SCHD) recognizes the right of consumers to voice their complaints. Complaints may be against:

1. A public health law or ordinance
2. A public health authority
3. A public health policy
4. A service provided/not provided

5. A situation related to services and/or care
6. An individual
7. Any other situation in which the consumer wishes to file a complaint

This policy provides a mechanism for the receipt, follow-up and resolution of complaints. The SCHD Health Director serves as the Consumer Complaint Coordinator.

Definitions:

1. Breach of Confidentiality**:** Inappropriate access to, use of, or release has protected health information.
2. ~~Consumer Comment: Verbal or written compliments, complaints, concerns, or observations made by Sampson County Health Department (SCHD) consumers regarding SCHD staff, services, facilities, or policies.~~

   Consumer Comment: Verbal or written compliments, complaints, concerns, or observations made by Sampson County Health Department (SCHD) consumers regarding laws/rules/regulations, policies, staff, services, facilities, or situations

.

3. Complaint A verbal or written expression of grief, pain, or dissatisfaction with a person or about a service, situation or law or authority that takes the form of a formal/informal accusation or charge. The person(s) making the complaint expects a specific corrective or other action to be taken.
4. Discrimination: Treating someone differently, or excluding or restricting services because of a person's race, color, descent, national or ethnic origin, sex, age, religion, or disability.
5. HIPAA Privacy Rule: – The Health Insurance Portability and Accountability Act of 1996, Public Health Law 101-194, 45 CFR 160 and 164, that regulates the use and disclosure of protected health information.
6. Protected Health Information (PHI): Any information, maintained in any form about the physical or mental health of an individual or payment for the provision of health care of an individual that identifies an individual and is transmitted electronically or otherwise, PHI does not include education records, covered by the Family Education Rights and Privacy Act (FERPA) or employment records held by a health care provider in its role as employer.
7. Title VI: The part of the Civil Rights Act of 1964 that prohibits any facility that receives federal assistance from discrimination in the provision of services on the basis of race, color or national origin. (These are the only topics addressed in this part of the Civil Rights Act.)

Responsible Persons:

All health department staff

Procedures:

1. Signage will be posted in the lobbies of the clinical, WIC and Environmental Health areas to inform consumers of the right to file a complaint.
2. If the consumer expresses a wish to file a complaint, he/she will be referred to any supervisor or the Health Director.
3. If the consumer wishes to file a verbal complaint, the supervisor will document the complaint on the complaint form.
4. If the consumer wishes to file a written complaint, a form and envelope will be given to the consumer. When the consumer has completed the form, he/she will place the form in the envelope and seal it.
5. The complaint form will be forwarded to the Health Director.
6. The Health Director will review the complaint, discuss the complaint with the appropriate supervisor.
7. The Health Director and Management Team will ensure at least 90% of complaints are followed up within ten (10) working days.
8. If the complaint is filed against a service, individual or situation, the department supervisor will be responsible for conducting a follow-up regarding the complaint, completing the ~~staff~~ follow-up portion of the form and returning the form to the Health Director.
9. The Health Director will be responsible for the follow-up of any complaints regarding a public health law or ordinance; a public health authority; or a public health policy. The Health Director may designate a department supervisor to assist with addressing the complaint.
10. Any patterns that are identified from complaints will be submitted to the QA team for review and/or solutions.

Note: ***In certain circumstances, the Health Director may submit the complaints directly to the Management Team for discussion.***

11. All complaints will be kept on file in the Health Director's office.

SAMPSON COUNTY HEALTH DEPARTMENT
Diversity Plan Policy & Procedures

Program: Administrative Manual	Applicable Signatures/Title
Title: Sampson County Health Department Diversity Plan Policy & Procedures	Program Coordinator/Specialist: N/A
□ Program Policy: _____Program	Supervisor: N/A
□ Program Procedure: _____Program	Director of Nursing: Vacant
(X) Management/Department-wide Policy	Medical Director: Dr. Allyn Dambeck
□ Personnel Policy	Health Director: Wanda Robinson RN
□ Fiscal Policy	Board of Health Chair: N/A
Distributed to: All Staff	Effective Date: 10/02/2018
	Supersedes: 10/02/2017

Purpose:

To assess the current level of diversity in the community to assist in developing strategic planning goals for public health staffing as it relates to the community population.

To recruit and retain an excellent and diverse workforce.

Policy:

The Sampson County Health Department (SCHD) strives to recruit and retain a diverse management team staff and employee workforce that mirrors the demographics of the community as best as possible in relation to gender and race/ethnicity.

SCHD strives to foster, maintain and promote equal employment opportunity. SCHD will select employees on the basis of the applicant's qualifications for the job and award them, with respect to compensation and opportunity for training and advancement, including upgrading and promotion, without regard to race, color, religion, sex, national origin, political affiliation, qualified disability, marital status, or age.

Procedures:

Implementation:

1. All personnel responsible for recruitment and employment will review this policy and relevant practices to assure that equal employment opportunity. This is based on:

    A. Reasonable, job-related job requirements being actively observed.
    B. No employee or applicant for employment will be discriminated against due to race, color, religion, sex, national origin, political affiliation, qualified disability, marital status, or age.

2. Applicants with disabilities will receive equal consideration for positions in which their disabilities do not represent an unreasonable barrier to satisfactory performance of duties.
3. Notices with regard to equal employment matters will be posted in conspicuous places on county premises in places where notices are customarily posted.

Recruitment, Selection and Appointment:

1. When position vacancies occur, the Sampson County Human Resources Director will publicize these opportunities for employment, including applicable salary information and required employment qualifications.
2. Information on job openings and hiring practices will be published in local and/or other news media as necessary to inform the community and create a qualified and diverse pool of applicants.
3. In addition, notice of vacancies will be posted at designated conspicuous sites within departments and in locations with a large minority population such as colleges and universities.
4. Individuals will be recruited from a geographic area as wide as necessary and for a period of time sufficient to ensure that a pool of well-qualified applicants are obtained for health department services.
5. The North Carolina Employment Security Commission is used as a recruitment source.
6. Employment advertisements will contain assurance of equal employment opportunity and will comply with Federal and State statutes.
7. All persons expressing interest in employment with the health department will be given the opportunity to file an application for employment for positions which are currently being recruited.

Data Guidelines:

SCHD uses statistical information based on county demographical information to review the current workforce demographics and to assist with planning for recruitment and retention of a diverse workforce. The information is reviewed on an annual basis.

1. County Demographics (US Census Bureau Quick Facts, 2017):

   The demographics of the citizens of Sampson County in relation to gender and race/ethnicity are as follows:

   A. Gender

      1. Male: 49.4%
      2. Female: 50.6%

   B. Race/Ethnicity

1. White: 67.0%
2. Black or African American: 26.6%
3. Native American: 3.3%
4. Other Races: 13.1%
5. Hispanic/Latino: 19.8%

(US Census Bureau Quick Facts, 2017)

2. Health Department Demographics:

The demographics of the Sampson County Health Department staff in relation to gender and race/ethnicity are as follows:

A. Gender

1. Male: 13%
2. Female: 87%

B. Race/Ethnicity

1. White: 52.6%
2. Black or African American: 28.9%
3. Hispanic/Latino: 15.7%
4. Native American: 2.6%

3. Strengths:

The department mirrors the race/ethnicity demographics of the county population. It was originally expected that the department's percent of minority staff would be lower than that of the community; however, the department has more minority staff (47.4%) than that of the community population (33%).

4. Needs:

A review of demographics based on gender indicates the health department needs to recruit a larger male population in an effort to more closely mirror the demographics of the community. The County's male population was an estimated 49.4% in 2017 compared to SCHD's 13%.

5. Plan:

The Sampson County Health Department plans to promote public health careers more to the male population specifically aiming towards male students.

A. Sampson County Health Department will plan to collaborate with the local high schools regarding health occupations classes in order to increase awareness of public health career path, especially for males.

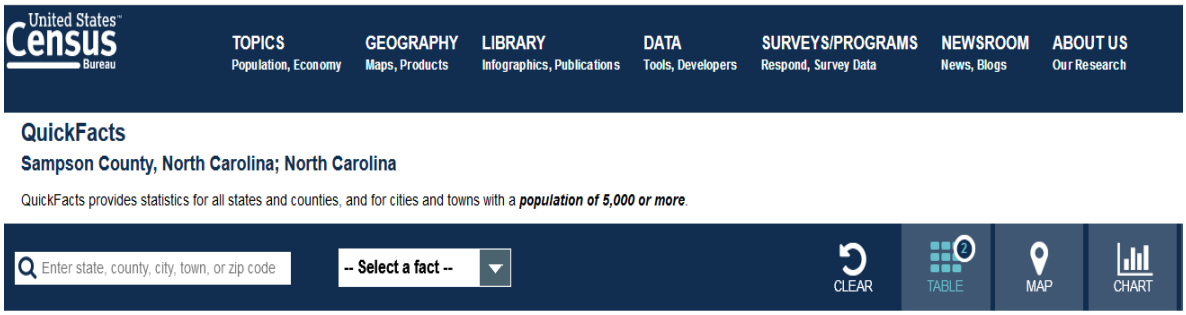
B. Sampson County Health Department will plan to collaborate with Sampson Community College to encourage more male college students to pursue the public health career path.

C. Sampson County Health Department will plan to collaborate with local and state educational institutions to encourage more males to pursue non-medical public health positions, such as financial or clerical.

References:

US Census Bureau Quick Facts, 2017.

US Census Bureau Quick Facts, 2017:



Table

All Topics	Sampson County, North Carolina	North Carolina
Population estimates, July 1, 2017, (V2017)	63,430	10,273,419
PEOPLE		
Population		
Population estimates, July 1, 2017, (V2017)	63,430	10,273,419
Population estimates base, April 1, 2010, (V2017)	63,469	9,535,721
Population, percent change - April 1, 2010 (estimates base) to July 1, 2017, (V2017)	-0.1%	7.7%
Population, Census, April 1, 2010	63,431	9,535,483
Age and Sex		

All Topics	Sampson County, North Carolina	North Carolina
Population estimates, July 1, 2017, (V2017)	63,430	10,273,419
Age and Sex		
Persons under 5 years, percent	⚠ 6.4%	⚠ 5.9%
Persons under 18 years, percent	⚠ 24.6%	⚠ 22.4%
Persons 65 years and over, percent	⚠ 17.3%	⚠ 15.9%
Female persons, percent	⚠ 50.6%	⚠ 51.3%
Race and Hispanic Origin		
White alone, percent (a)	⚠ 67.0%	⚠ 70.8%
Black or African American alone, percent (a)	⚠ 26.6%	⚠ 22.2%
American Indian and Alaska Native alone, percent (a)	⚠ 3.3%	⚠ 1.6%
Asian alone, percent (a)	⚠ 0.6%	⚠ 3.1%
Native Hawaiian and Other Pacific Islander alone, percent (a)	⚠ 0.3%	⚠ 0.1%
Two or More Races, percent	⚠ 2.2%	⚠ 2.2%
Hispanic or Latino, percent (b)	⚠ 19.8%	⚠ 9.5%
White alone, not Hispanic or Latino, percent	⚠ 51.0%	⚠ 63.1%
Population Characteristics		
Veterans, 2012-2016	3,581	683,221
Foreign born persons, percent, 2012-2016	9.7%	7.7%

SAMPSON COUNTY HEALTH DEPARTMENT
Facility & Equipment Cleaning Policy & Procedure

Program: Administrative Manual	Applicable Signatures/Title
Title: Sampson County Health Department Facility & Equipment Cleaning P & P	Program Coordinator/Specialist: N/A
☐ Program Policy: _____Program	Supervisor: N/A
☐ Program Procedure: _____Program	Director of Nursing: Vacant
(X) Management/Department-wide Policy	Medical Director: Dr. Allyn Dambeck
☐ Personnel Policy	Health Director: Wanda Robinson RN
☐ Fiscal Policy	Board of Health Chair: Jacqueline Howard
Distributed to: All Staff	Effective Date: 10/02/2018
	Supersedes: 10/02/2017

Purpose:

To assure that Sampson County Health Department (SCHD) has a method to disinfect any and all medical instruments and/or medical equipment used during patient care in the effort to adhere to infection control recommendations and guidelines.

Policy:

The Sampson County Health Department (SCHD) understands the importance of infection control in the outpatient healthcare setting to reduce the risk of transmission infections and diseases to SCHD clients and personnel. Infection control involves a variety of procedures to help reduce the risk of infection transmission. This policy provides guidance to personnel regarding cleaning and disinfecting methods. SCHD follows the Federal Office Safety and Health Administration (OSHA) and the Centers for Disease Control and Prevention (CDC) guidelines regarding infection control.

~~clinical staff and interpreters will be responsible for the cleaning of medical instruments and equipment after each patient use and/or as recommended by established infection control standards in the clinical area. Laboratory staff will be responsible for the cleaning of medical instruments and equipment after each patient use and/or as recommended by established infection control standards in the laboratory area. WIC staff will be responsible for the cleaning of medical instruments and equipment after each patient use and/or as recommended by established infection control standards in the laboratory area. Sampson County Health Department will use EPA-registered disinfectants in accordance with the manufacturer's instructions for disinfecting surfaces, equipment and instruments.~~

Definitions:

EPA: Environmental Protection Agency
Environmental Surfaces: flat surface areas that may become contaminated.
Infection Control: a means of limiting exposure to infectious organisms.

Personal Protective Equipment (PPE): protective barrier devices to protect the wearer from contamination; should be appropriate for the task and type of contamination.

Applicable Laws, Rules & Regulations:

OSHA Blood-borne Pathogen Standard – 29 CFR – 1910.1030
CDC MMWR Recommendations and Reports MMWR 52(rr10);1-42; June 6, 2003: Guidelines for Environmental Infection Control in Health-Care Facilities

Responsible Persons:

Clinical Staff
Laboratory Staff
WIC Staff
All Other Staff as indicated

Equipment Required:

Latex and/or Vinyl gloves
Face shields/goggles
Paper towels
EPA-registered, hospital-grade disinfectants
Alcohol

Procedures:

Overview:

1. Sampson County Health Department will use EPA-registered disinfectants in accordance with the manufacturer's instructions for disinfecting surfaces, equipment and instruments.
2. Clinical staff and interpreters will be responsible for the cleaning of medical instruments and equipment after each patient use and/or as recommended by established infection control standards in the clinical area.
3. Laboratory staff will be responsible for the cleaning of medical instruments and equipment after each patient use and/or as recommended by established infection control standards in the laboratory area.
4. WIC staff will be responsible for the cleaning of medical instruments and equipment after each patient use and/or as recommended by established infection control standards in the laboratory area.
5. Environmental Health staff will be responsible for the cleaning of instruments and equipment used during the performance of job duties as indicated by NC Environmental Health Division guidance.
6. A record of cleaning is documented on various logs used throughout the agency. Refer to the Appendix, Attachment A for the logs.

Cleaning & Disinfecting Environmental Surfaces:

1. **Wear gloves to clean**
2. Use an EPA-registered, hospital-grade disinfectant and use in accordance with the disinfectant's label instructions and in accordance with the equipment's manufacturer's instructions
3. Do not use alcohol to disinfect large environmental surfaces.

Cleaning Spills of Blood & Body Substances:

1. Promptly clean and decontaminate spills of blood or other potentially infectious materials according to the health department Exposure Control Plan.
2. Use spill kits located in the Laboratory and the WIC Lab.

Cleaning Frequency of Instruments & Equipment:

1. Earpieces and bell of the stethoscope will be cleaned with alcohol after each day of patient use and as needed; otoscope/ophthalmoscope units will be cleaned at the end of each day and as needed.
2. Ear speculums will be discarded after each use.
3. Vaginal speculums will be discarded after each use.
4. Ear pieces on audiometer will be cleaned with alcohol after each day of use or after using on a patient who has ear drainage or red canal. Disposable pieces will be discarded after each use.
5. Speculum light cords will be wiped daily after patient use with an EPA-registered disinfectant.
6. Exam beds will be wiped down after each day of use and as needed with an EPA-registered disinfectant.
7. Disposable exam bed covers and exam gowns/sheets will be used and will be discarded after each use by a patient.
8. Counters, sinks, chairs, door handles and scales will be wiped down after each day of use and as needed with an EPA-registered disinfectant.
9. Vaccine refrigerators will be cleaned at least annually or when soiled with an EPA-registered disinfectant
10. The autoclave:

    A. Instruments are soaked and cleaned per the autoclave manufacturer's instructions.
    B. The autoclave machine is monitored and cleaned per OSHA, CDC and the manufacturer's guidelines and instructions. This includes, but is not limited to:

        1. Performing a weekly spore check
        2. Cleaning the machine at least monthly or more often depending on the number of uses based on CDC guidance and the Manufacturer's Operations Manual.
        3. Record findings and cleanings in the logs

    C. Refer to the Appendix, Attachment B for CDC guidance.

Cleaning Schedule for Clinical, Laboratory and WIC Areas:

1. **Wear gloves to clean.**
2. At the end of the workday and as needed, the clinical interpreters and nursing staff will clean the countertops, sink, exam table, stools, weight scales and door handles in all exam rooms.
3. Laboratory staff will clean the phlebotomy station, countertops, sink, stools, lab chairs and door handles in all laboratory rooms.
4. WIC staff will clean the countertops, sink, stools, lab chairs, weight scales and door handles in all laboratory rooms and breastfeeding rooms/chairs.
5. Environmental surfaces in any health department area will be cleaned as needed whenever they are contaminated.

Documentation of Cleaning Frequency:

Staff performing the required cleaning will document their performance by putting their initials on the Cleaning Schedule Log which is located: in each exam room; the laboratory central work station; and the WIC Lab room.

Cleaning Schedule for Jantorial Contractor:

~~Health Department cleaning is provided by a contractor who will provide at minimum:~~

1. SCHD contracts with a cleaning company that is responsible for the routine cleaning and maintenance of SCHD and is responsible for supplying and/or using the required disinfection cleaning products.
2. The contractor is responsible for the training of contract staff regarding disinfection and cleaning practices.
3. The contractor is responsible for meeting all disinfecting and cleaning requirement as indicated by the cleaning schedule – refer to the Appendix, Attachment A for the Cleaning Schedule. Routine disinfecting and cleaning includes, but is not limited to:

   A. Sweep/vacuum floors daily.
   B. Empty all clinical trash cans twice daily.
   C. Empty all biohazard receptacles daily.
   D. Empty all other trash cans daily.
   E. Disinfect/clean patient and public bathroom sinks and toilets daily.
   F. Mop floors daily.

References:

OSHA Blood-borne Pathogen Standard – 29 CFR – 1910.1030
CDC MMWR Recommendations and Reports MMWR 52(rr10);1-42; June 6, 2003: Guidelines for Environmental Infection Control in Health-Care Facilities
SCHD OSHA Manual
SCHD Laboratory Policy & Procedures Manual

SAMPSON COUNTY HEALTH DEPARTMENT
Incident Reporting Policy and Procedure

Manual: Administrative Manual	Applicable Signatures/Title
Title: Sampson County Health Department Incident Reporting P&P	Program Coordinator/Specialist: N/A
☐ Program Policy: _____Program	Supervisor: N/A
☐ Program Procedure: _____Program	Director of Nursing: Vacant
X Management/Department-wide Policy	Medical Director: Dr. Allyn Dambeck
☐ Personnel Policy	Health Director: Wanda Robinson
☐ Fiscal Policy	Board of Health Chair: Jacqueline Howard
Distributed to: All Personnel	Effective Date: 10/02/2018
	Supersedes: 10/02/2017

Purpose:

To provide department-wide guidelines to ensure timely, appropriate reporting of any unusual event or circumstance involving Sampson County Health Department (SCHD) personnel, clients or visitors.

Policy:

Sampson County Health Department is aware of the need to document the occurrence of events or circumstances that may affect the normal operating procedures of SCHD. SCHD is committed to ensuring that these events receive attention, are reviewed and steps are taken to prevent future incidences when possible.

Definitions:

Incident: Any unusual event or circumstance that is: not consistent with normal, routine operations of the Sampson County Health Department (SCHD) and staff; directly related to situations involving potential medical or general liability issues; not related to property damage, theft or vandalism; and/or not related to employee performance, complaints or injuries UNLESS the event/circumstance involves client care.

Procedures:

Responsibility:

1. All Health Department personnel are responsible for any incident in which they participate or of which they are aware. All incidences are to be reported following the guidelines below.
2. Examples of Incidents:

    A. Client/visitor/personnel slip and/or fall

B. Unusual conduct by client, relative or visitors
C. Medication errors
D. Potential hazards, such as life-saving procedures, fire equipment or other equipment malfunction that may threaten personnel/client/visitor safety
E. Accidents in which clients/personnel/visitors are injured/die
F. Unexpected outcomes of treatments or procedures
G. Mistaken identity
H. Serious drug reaction
I. Delay/failure to diagnose/treat that results in unexpected complications
J. Any occurrence that may result in medical/legal issues.

3. Summon medical/other assistance as needed.
4. Report incident immediately to:

A. ~~Nursing Director~~ Health Director
B. ~~Health Director if Nursing Director unavailable~~ Department Supervisor if the Health Director is unavailable
C. Physician as indicated

5. Complete Incident Report Form as completely and as accurately as possible.
6. Complete any other applicable forms as needed.
7. **ALL INCIDENCES MUST BE REPORTED WITHIN 24 HOURS**
8. **NOTE:** ***The form is NOT a part of a client record. NO copies of the form are to be made or any part placed in a client's chart.***
9. Separate documentation may be done in the client's chart on the Progress Notes if applicable. Documentation should include the facts of the incident, steps taken and outcome if the incident relates to the client's care.
10. The original Incident Form is to be completed, placed in an envelope marked "Confidential" and forwarded to the ~~Nursing~~ Health Director. If the ~~Nursing~~ Health Director is unavailable, forward the Incident Form to the ~~Health Director~~ Department Supervisor.
11. The ~~Nursing~~ Health Director will review and log the report, then forward the Incident Form to the ~~Health Director~~ appropriate Department Supervisor within three (3) working days.
12. The ~~Nursing Director~~ Department Supervisor will be responsible for the follow-up and feedback of all Incident Reports and returning the form and information to the Health Director within ten (10) working days.
13. Recommendations will be forwarded to the ~~Health Director,~~ the Management Team, and the Quality Assurance Team for feedback.

Revised 06/22/06; 01/28/2009; 8/2013; 8/2014; 08/03/2015; 8/03/2016; 10/02/2017; 10/02/2018

SAMPSON COUNTY HEALTH DEPARTMENT
Professional Liability Policy and Procedure

Manual: Administrative Manual	Applicable Signatures/Title
Title: Sampson County Health Department Professional Liability P&P	Program Coordinator/Specialist: N/A
☐ Program Policy: _____Program	Supervisor: N/A
☐ Program Procedure: _____Program	Director of Nursing: Vacant
X Management/Department-wide Policy	Medical Director: Dr. Allyn Dambeck
☐ Personnel Policy	Health Director: Wanda Robinson
☐ Fiscal Policy	Board of Health Chair: Jacqueline Howard
Distributed to: All Personnel	Effective Date: 10/02/2018
	Supersedes: 10/02/2017

Purpose:

To provide guidance and information to all agency departments concerning general and professional liability coverage.

Policy:

The Sampson County Health Department (SCHD) will provide professional liability insurance coverage for the employees of the Sampson County Health Department. Coverage will be renewed annually and copy of the policy will be kept in the Administrative Assistant's office.

Applicable Law, Rules and Regulations:

County of Sampson Administration Policy for County Departments

Responsible Persons:

Health Director

Procedures:

1. Under the County of Sampson Administration Policy, each county department is required to provide professional liability insurance coverage for its personnel.
2. SCHD maintains professional liability insurance through the North Carolina Association of Local Health Directors CHUBB Plan
3. The Health Director or designee will ensure that all SCHD personnel are covered at all times by ensuring:

   A. Premiums are paid in a timely manner.
   B. Coverage policies are renewed annually.

References:

North Carolina Association of Local Health Directors: ACE American Insurance Company Healthcare Professional Liability Policy.

Sampson County Health Department
Research Policy & Procedures

Program: Administrative Manual	Applicable Signatures/Title
Title: Sampson County Health Department Research Policy & Procedures	Program Coordinator: Vacant
☐ Program Policy: _____Program	Supervisor: N/A
☐ Program Procedure: _____Program	Director of Nursing: Vacant
(X) Management/Department-wide Policy	Medical Director: Dr. Allyn Dambeck
☐ Personnel Policy	Health Director: Wanda Robinson RN
☐ Fiscal Policy	Board of Health Chair: Jacqueline Howard
Distributed to: All Staff	Effective Date: 10/02/2018
	Supersedes: 10/02/2017

Purpose:

To provide guidelines regarding participation in research studies conducted by Sampson County Health Department or any agencies seeking participation from SCHD clients.

Policy:

It is the policy of the Sampson County Health Department to participate in research studies sponsored by government and other agencies that can provide incite or information regarding subjects that can improve the health and well-being of the citizens of Sampson County.

The US Department of Health and Human Services, Office for Human Research Protections (OHRP) provides leadership on human research subject protections and implements a program of compliance oversight the protection of human subjects - Title 45, Part 46 of the Code of Federal Regulations (45 CFR part 46).

North Carolina academic institutions and the North Carolina Department of Health & Human Services (NC DHHS) follow these regulations in policies detailed by the Institutional Research Board (IRB), which governs all research within these agencies and adheres to the highest standards in research practices. All applicable North Carolina General Statutes and administrative codes will be observed.

Applicable Laws and Rules:

Code of Federal Regulations: Title 45, Part 46; § 45CFR 46.
Code of Federal Regulations: Title 21, Part 50; 2§ 1 CFR 50.
North Carolina General Statute § 130A-374
10A NCAC 47A.0102
10A NCAC 13B.3302

Responsible Persons:

All Health Department Staff that participates in any manner in research projects.

Procedures:

Client Participation:

1. Clients will be informed that participation in a research study is voluntary.
2. Research studies will not adversely affect the client's physical, social, psychological or financial well-being.
3. Research studies that are undertaken are to have a goal to assist in improving the health status of Sampson County residents, as well as North Carolina's general population.
4. All studies will be established in such a way to protect the participant's identity, rights, privacy, anonymity, financial status and confidentiality.

Health Department Participation:

1. All inquiries for permission to conduct health research studies in the county should be directed to the Health Director.
2. A written request and research proposal is to be submitted to the Health Director.
3. A meeting to discuss details of the research study will be scheduled between all parties.
4. A detailed research proposal and written IRB proposal will be placed on file at the Health Department prior to the study beginning.

Agencies' Responsibilities:

1. The Health Director will approve local health studies involving county participants when relevant.
2. An academic institution or any other outside agency will develop a research proposal detailing the study objectives, procedures, and proposed outcomes.
3. The academic institution or outside agency will obtain and submit written IRB approval prior to the study, and a copy must accompany the research proposal submitted to the Health Department.
4. The Health Director will appoint personnel to serve as liaison(s) to the research study.
5. The Family Planning Coordinator will notify the Women's Health Branch and the Regional Title X Office in writing of any research project involving Title X clients.

Health Department as Host Agency:

1. Under normal circumstances, SCHD does not serve as the host for research projects. In the event that another agency or the State would request that SCHD serve as a host agency for any research project, SCHD will follow all guidelines, rules and regulations for establishing itself as the research project host.
2. SCHD will follow all of the processes in § 45CFR 46 and North Carolina laws to ensure all laws and regulations have been met to host a research project.
3. SCHD will ensure all research participants rights are protected under federal and state laws.

SAMPSON COUNTY HEALTH DEPARTMENT
Staff Qualifications and Development Policy & Procedures

Manual: SCHD Administrative Manual	Applicable Signatures/Title:
Title: Sampson County Health Department Staff Qualifications & Development	Program Coordinator/Specialist: N/A
□ Program Policy: _____Program	Supervisor: N/A
□ Program Procedure: _____Program	Director of Nursing: Vacant
X Management/Department-wide Policy	Medical Director: Dr. Allyn Dambeck
□ Personnel Policy	Health Director: Wanda Robinson
□ Fiscal Policy	Board of Health Chair: Jacqueline Howard
Distributed to: All Personnel	Effective Date: 10/02/2018
	Supersedes: 10/02/2017

Purpose:

To provide quality services by training and retaining a quality workforce.
To identify ways to recruit and retain diverse, qualified management staff and employees.
To train employees for high productivity.
To identify and provide required, needed or recommended trainings for staff.

Policy:

This policy shall assure Sampson County Health Department compliance with county, state and federal laws and regulations as well as the recruitment and retention of highly qualified and diversified management team and health department staff members in order to enhance the provision of high quality services to clients. As a public health agency, the Sampson County Health Department is required to comply with public health laws, rules and regulations. The health department will enhance personnel development by identifying educational requirements, needs and training to assure staff members are adequately educated, trained and credentialed for their positions.

Definitions:

Competent: Capable, knowledgeable and qualified to perform the assigned duties and responsibilities
Validate: To confirm or verify competency
Employees: All hired, contracted or volunteer persons working on behalf of the agency

Laws, Rules, Regulations:

North Carolina General Statute 130A, Article 2.
10A North Carolina Administrative Code (NCAC) 46; Section .0300 – 0301.

Responsible Persons:

All Health Department Personnel

Procedures:

Orientation:

1. All staff members are required to complete an orientation program based on the position and agency departments and programs – see Orientation Policy.
2. The length of time required for orientation is based on the employee's job position – see Orientation Policy.
3. All new employees will complete their Orientation Guide – see Orientation Policy.

Performance Review & Appraisals:

1. Employees appointed to full-time positions will serve a probationary period of a minimum of six months.
2. During the probationary period, new employee review will consist of:

    A. Weekly performance review and goal setting using the New Staff Orientation Part 1 Form for the first 90 (3 months) days until the 90 (3 month) performance appraisal – see Orientation Policy.
    B. Once the 90 (3 month) day performance appraisal has been completed, the monthly New Staff Orientation Part 2 Form will be used for the next 90 (3 months) days until the 180 (6 month) day performance appraisal – see Orientation Policy.

3. During the probationary period, performance appraisals will be performed after 30 (one month), 90 (three months) and 180 days (six months)of employment until the probationary period has ended to assist employees with accomplishments, strengths, weaknesses and areas identified that need improvement.
4. Initial competency will be completed at the end of one month (30 days) of hire, then annually thereafter or as needed – see General Staff Competency Requirements: below.
5. Performance appraisals may be performed more frequently based on any identified areas that need to be addressed more often.
6. The probationary period may also be extended beyond the 180 (6 months) days based on any identified areas that need additional appraisal.
7. Once the probationary period has ended, annual employee appraisals will be done during the anniversary month of hire.
8. The probationary appraisal will consist of:

    A. The employee's progress that includes:

1. Accomplishments
2. Strengths
3. Weaknesses
4. Goals/Areas needing improvement

B. Review of satisfactory completion of job duties/work
C. Recommendation to end or extend the probationary period

5. The annual performance appraisal will consist of:

A. Review of the Employee Self-Appraisal
B. Review of the employee's job performance during the previous year
C. Identification of strengths, weakness, areas needing improvement
D. Any extenuating factors affecting job performance
E. Goals and/or needed improvements for the next evaluation period
F. Review of the job description
G. Review of Title X competencies if applicable
H. Review of nursing competencies
I. Review of employee competencies.

Qualifications:

The Sampson County Health Department shall comply with the North Carolina Administrative Code, 10A NCAC 46.0300 – .0301 Local Health Department Staff, which identifies the "Minimum Standard Health Department: Staffing." In compliance with this rule, the following shall be mandated for staff.

General Staff Competency Requirements:

1. Recruitment and selection of employees will follow state and/or local personnel policies related to hiring and include verification of education, experience and training. Verification of licensure and/or certification will be conducted as appropriate to specific position requirements.
2. All positions will have a current signed and dated job description defining qualifications, knowledge, skills and abilities required for the position.
3. All new employees will receive a thorough agency general and job specific orientation which outlines specific areas of knowledge and skills required for the position. Employees changing positions or job responsibilities will receive an orientation to the new requirements of the position.
4. The Department Supervisor will be responsible for assuring the orientation process and verification of competency of the employee to include:

A. The established time frame of the new employee orientation period will be individualized according to the employee's job requirements and identified needs.

B. An initial competency assessment will be performed within 30 days of hire.
C. All new employees will satisfactorily demonstrate skills of the assigned job prior to being assigned independently to the job duties.

5. SCHD will ensure all staff are competent in their duties and will guide the total process and will include the following competency verification procedures:

A. Awareness of the core functions and essential services of public health and the core competencies for public health employees as well as any specific competencies for disciplines such as nursing, WIC and environmental health.
B. Utilization of job specific skills lists with designated activities and timeframes for completion and verification of competency of the assigned skills.
C. Designated mentor or preceptor/s to foster an environment of supported learning.
D. Employee, mentor/preceptor and supervisor evaluation and feedback including a plan for improvement or continued growth as indicated according to the established time frame.

4. Ongoing competency of employees will be assessed: at a minimum annually; during orientation; when new procedure and techniques are introduced; when job duties change; and by individual performance. The Department Supervisor will be responsible for assessing and assuring verification of ongoing competency and developing, along with the employee, a plan for remediation and continued improvement as indicated. Methods for verification will include:

A. Orientation and annual agency employee performance appraisal/work-plan utilizing required duties and responsibilities of the job description and including future goals and plans.
B. Annual competency assessments utilizing checklists of key job skills including self-evaluation, demonstration and supervisor observation/evaluation with improvement plans as indicated.
C. Interim competency assessments to assess competence as new procedures or techniques are introduced, when job duties change and as indicated by individual performance.
D. Verification and copies of current licensure and certifications as required. Assurance of completion of required or recommended trainings as appropriate for the assigned responsibilities.
E. Review and/or performance by the supervisor of record audits as applicable to the position.
F. Utilization of reports of incidents, accident trends, customer satisfaction feedback and staff input as indicated.

5. Competency assessment with observation and training may be utilized at any time during employment by the Department Supervisor or designee when:

   A. The employee requests it.
   B. The employee has rated themselves as needing improvement or lacking in knowledge and/or skill for the assigned job.
   C. When patterns/trends are identified demonstrating an inability to perform the assigned job satisfactorily.

6. The agency will promote and encourage competency of employees by providing access to educational materials and trainings required for the position and as possible, other opportunities to enhance the growth of the employee's skills and abilities to perform the job. The agency will assure that any on the job training is provided by qualified and/or competent trainers.

Health Director Qualifications & Competency:

1. The Sampson County Board of Health will ensure the Health Director has and maintains the required credentials to serve in the capacity of Health Director per North Carolina General Statute 130A: 40-41.
2. The Health Director is responsible for providing the appropriate credentials to the Board of Health.

General Nursing Department Staff Competency and Responsibilities:

1. To assure the initial and ongoing competence of employees in order to provide quality public health services to all clients of the Sampson County Health Department (SCHD, each section of the nursing department is expected to meet minimum competency standards. This includes, nurses, social workers, interpreters, lab techs and any other employee providing nursing department services.
2. Sampson County Health Department (SCHD) will ensure the assessment of the competency of nursing department employees to perform the necessary skills for their assigned duties and responsibilities initially and ongoing, at least annually. The Nursing Director will ensure the competency of staff. SCHD will provide a work environment which promotes self-development and continued learning.
3. Tools developed by the North Carolina Division of Public Health, Local Technical Assistance and Training Branch & Public Health Nursing and Professional Development Unit will be used as a basis to measure competency for all nursing department staff.
4. The competency tool will be used within 30 days of hire to measure the employee's initial competency and to set goals for the employee for the next twelve months.
5. The tool will be used to measure competency during the employee's annual performance appraisal and the information will be used to determine areas needing improvement and/or goal setting for the next performance period.

6. The competency tools may be used at any time to measure competency for any employee or for a specific competency measure. Examples may include interviewing, vital sign measurements, documentation, etc.

Nursing Licensure, Scope of Practice, Qualifications & Responsibilities:

SCHD will assure a qualified public health workforce and ensure nursing staff have and maintain appropriate licensures and credentials. All nursing staff will hold a current nursing license.

1. General Responsibilities:

The Nursing Director will be responsible for ensuring appropriate orientation for each staff member, which is usually six (6) weeks; however, this time period may be expanded based on the position and the amount of initial orientation/training needed for the position.
The Nursing Director is responsible for ensuring staff receives appropriated training for the position, which may include webinars, online courses, meetings, facility-based courses and inservices.
The Nursing Director is responsible for tracking staff certification, training and licensure and will review certification and licensure for nursing staff. She will inform staff of the following information requirements:

A. All professional licenses shall be verified at the time of renewal. Each nurse will be responsible for providing the Nursing Director with a copy of a current nursing license before hire and when renewed.
B. The Nursing Director will verify licensure on the NC Board of Nursing Website—www.ncbon.com.
C. Verification of continuing educational credits shall be reported to the Nursing Director at the time credit is received. The employee will be responsible for providing the Administrative Assistant with a copy of the certification to be placed in the employee's personnel file.
D. The employee will notify the Nursing Director when the *Introduction to Principles and Practices of Public Health Nursing* course or expanded role trainings, such as Child Health or STD Enhanced Role Registered Nurse Courses are successfully completed. The employee will provide the Nursing Director and the Administrative Assistant a copy of the training certificate.
E. All SCHD licensed healthcare professionals that provide prenatal services will receive Fetal Monitoring Training every two (2) years in order to be able to perform Non-Stress Testing (NST) when indication warrants. SCHD healthcare professionals requiring the training include the Clinic Registered Nurses and Nurse Practitioners.

2. Scope of Practice:

   A. All Public Health Nurses will abide by the North Carolina Board of Nursing Practice Act.
   B. The Nurse Practice Act provides legal parameters within which a nurse with a verified license may practice in North Carolina.

3. Category II:

   A. Certain activities are within the scope of nursing practice for Public Health Nurses provided the North Carolina Board of Nursing has been notified that there is:

      1. A written protocol to include standing orders as needed.
      2. Documentation of appropriate training and supervised clinical practice.
      3. Written approval by the nursing administration, agency administration and medical staff of the agency.

   B. Category II policies, protocols and/or procedures will be updated and signed annually.
   C. A roster of staff approved for Category II procedures will be maintained in the Nursing Director's Office.

4. Mandatory Training for Clinical Services:

   A. OSHA/Bloodborne Pathogens Training
   B. CPR
   C. HIPAA
   D. Title X Competency Trainings
   E. POHR
   F. CureMD EHR
   G. Documentation, Coding and Billing
   H. NCIR
   I. Fetal Monitoring Training

5. Mandatory Training for Outreach Services:

   A. OSHA/Bloodborne Pathogens Training
   B. CPR
   C. HIPAA
   D. Title X Competency Trainings
   E. POHR
   F. CureMD EHR
   G. Documentation, Coding and Billing
   H. NCIR

I. Prenatal Care Management (OBCM) Training
J. Care Coordination for Children (CC4C) Training
K. Motivational Interviewing Training
L. Postpartum/Newborn Home Visit Training
M. Mental Health First Aid Training

6. Individual Nurse Responsibilities:

A. Each nurse must hold a registered nursing license that is determined to be valid by the North Carolina Board of Nursing (NCBON) and must provide the Nursing Director a copy of the licensed upon hire and at each renewal.
B. Any nurse without or suspected of being without a valid nursing license will be suspended immediately from nursing duties until a determination is made regarding the status of a valid nursing license that is compliant under the rules and regulations of the North Carolina Board of Nursing.
C. Each nurse is responsible for following NCBON requirements for annual continuing educational contact hours and competencies.
D. Possess a baccalaureate nursing degree from a National League of Nursing accredited school OR complete the North Carolina Department of Public Health's *Principles & Practices of Public Health Nursing* Course within one year of hire.
E. Will complete formal education or training needed to perform Category II Nursing Activities within the scope of nursing practice as indicated by each nurse's job function(s). These include:

1. Dispensing of Drugs by Public Health Nurses
2. HIV Prevention Counseling & Testing
3. Physical Assessment of Adults
4. Physical Assessment of Children
5. STD Clinician Training
6. Communicable Disease/TB Clinician Training
7. Diabetes Training
8. Title X Competency Form within 30 days of hire and then annually at performance appraisal.
9. Job competency assessment

F. Each nurse is responsible for obtaining and maintaining competency in their area of work. The competency form will be completed for each nurse during the annual performance appraisal.

Public Health Nurse I:

1. Classification salary ranges are set by the state personnel office and county commissioners.
2. Must hold a registered nursing license that is determined to be valid by the North Carolina Board of Nursing.

3. Must complete the following staff development within six months of hire unless otherwise indicated:

    A. Dispensing of Drugs by PHNs
    B. CPR
    C. OSHA/Bloodborne Pathogens within 10 days of hire and annually
    D. Principles and Practices of Public Health if does not have BSN degree within one year of hire; RNs with a BSN or higher degree will be required to take the online Introduction to Public Health Course. Refer to the Orientation Policy and Procedures.
    E. HIPAA
    F. Program-specific training as required or indicated by state or health department guidelines:

        1. Care Coordination for Children
        2. Pregnancy Care Management
        3. Immunizations
        4. CD/TB Orientation

<u>Public Health Nurse II and III (Program Coordinator/Enhanced Role Nurse):</u>

1. Must meet all of the requirements of the Public Health Nurse I (PHN I).
2. Must meet all of the following requirements listed for the program before eligible for salary and fringes as indicated by the position.

3. Breast and Cervical Cancer Control/WISEWOMAN Program:

    A. BCCCP Trainings
    B. WISEWOMAN Trainings

4. Child Health/Immunizations:

    A. Child Health Enhanced Role Training Course
    B. Bright Futures Training
    C. Testing Certification
    D. OAE Certification
    E. Communicable Disease Clinician Course
    F. Immunization/NCIR Course
    G. NC EDSS Course

5. Communicable Disease:

    A. Communicable Disease Clinician Course
    B. TB Orientation Course
    C. Immunization Course
    D. NC EDSS Course

6. Sexually Transmitted Disease

    A. Adult Physical Assessment Course
    B. Sexually Transmitted Disease Enhanced Role Clinician Course
    C. Communicable Disease Clinician Course
    D. TB Orientation Course
    E. Immunization Course
    F. NC EDSS Course

7. Other Program Requirements

    A. In addition, other programs may require additional training based on the program and/or any grants received.
    B. All program coordinators will be responsible for training and implementation of the Cervical Cytology Manual policy/procedures and any needed follow-up for their program as required by state and federal guidelines.
    C. Thorough understanding of their program's Agreement Addendum(s) and the requirements for their program(s).
    D. All program coordinators will be responsible for training and meeting requirements as mandated by state/federal guidelines that may not be listed in this policy.

Nurse Practitioner:

1. Classifications and salary ranges are determined by the state personnel office and the county commissioners.
2. Must hold a registered nursing license that is determined to be valid by the North Carolina Board of Nursing (NCBON) and the North Carolina Board of Medical Examiners (NCBME).
3. Must hold a valid DEA license.
4. Must ensure fifty mandatory contact hours annually as required by the NCBON and NCBME.
5. Within three (3) months of hire, all new midlevel or higher medical providers that provide assessment and/or management of STD clients will complete the Alabama/North Carolina HIV/STD Prevention Training and a one-day STD clinical practicum. SCHD will notify the DPH STD Regional Consultant to arrange the training.

Laboratory Personnel:

1. Classification and salary ranges are determined by the state personnel office and the county commissioners.
2. Training needs will be assessed during orientation period and competency testing.

3. Laboratory personnel will follow all North Carolina State Laboratory of Public Health (NCSLPH) requirements and recommendations for training and continuing education.
4. Competency testing for personnel performing laboratory procedures will be conducted by the regional NCSLPH consultant or the Health Department Laboratory Manager.
5. Laboratory personnel will ensure that they maintain a minimum of six hours of continuing education annually as required by the NCSLPH.
6. Required to attend mandatory inservices and trainings.

Social Worker:

1. Classification and salary ranges are determined by the state personnel office and the county commissioners.
2. Orientation is based on job placement.
3. Required to attend the same mandatory inservices as nursing personnel.

Environmental Health Specialists:

1. Environmental Health Specialists employed by the Department shall be delegated authority by the State to administer and enforce State environmental health rules and laws as directed by the State pursuant to G.S. 130A-4(b). This delegation shall be done according to 15A NCAC 18A .2300, as follows:
2. The Health Department is responsible for sending their newly employed environmental health specialists (interns) to the State mandated centralized intern training conducted in Raleigh, North Carolina.
3. Each Environmental Health Specialist will be responsible for completing all state-required orientation trainings – See Orientation Policy.

Registered Dietitians:

1. A copy of approved Learning Plan (which has been submitted to Credentialing on Dietetic Registration – CDR) must be provided to the Nutrition Director.
2. All newly hired nutritionists/RD's will attend a State approved breastfeeding training.

Breastfeeding Coordinator:

1. Successful completion of the North Carolina Lactation Educator Training Program; or
2. Other State-required breastfeeding training programs.
3. A minimum of 20 hours of continuing education in breastfeeding every 5 years.

Breastfeeding Peer Counselor:

1. Successful completion of the North Carolina Breastfeeding Peer Counselor Training Program; or
2. Attend other State-required Breastfeeding Peer Counselor training programs.
3. Attend NC Lactation Educator trainings.

WIC Vendor Coordinator:

1. Attend yearly vendor coordinator webinar trainings.
2. Attend other state-required WIC vendor trainings.

Health Educator:

1. Completion of trainings and courses required by state health education and promotion branches and requirements of any grants received.
2. Completion of trainings and courses required by the Health Director in order to provide health education and promotion services to the community.

Interpreter:

1. Completion of trainings required by state/federal authorities or guidelines.
2. Completion of Interpreter Certification Courses I & II.
3. Completion of trainings and courses required by the Health Director in order to provide interpreting services to clients and the community.

Medical Records/Intake-Eligibility/WIC Staff:

1. Completion of trainings required by state/federal authorities or guidelines.
2. Completion of trainings and courses required by the Health Director in order to provide services to clients and the community.

Training Plan:

1. Supervisors shall be responsible for ensuring appropriate training is provided for his/her staff and discussing the plan with the Health Director for approval and incorporation in the agency's total plan, including the budget.
2. Selection of offerings shall be based on: State/Agreement Addenda requirements, health department requirements, program requirements, relevance of the topic, availability of funds, faculty and sponsoring group, continuing education credit offered and adequate staff coverage.
3. Criteria for selection of staff training is based on need, previous contribution and Potential, such as:

    A. Required training; e.g., PHN I.
    B. Job skills.

C. Demonstrated interest and potential for developing in a specific area of training.
D. Plan and commitment by the agency and employee to function in the area of training.
E. Degree of responsibility for sharing new knowledge and skills with other staff.
F. Demonstrated interest in professional growth.
G. Reasonable distribution of responsibilities.

4. Requests for workshops, educational conferences and meetings should be to the appropriate department supervisor on the travel request form with a copy of the offered training attached.
5. The supervisor will evaluate the request, approve or deny and route accordingly.
6. Supervisors shall be responsible for remaining abreast of any changes in laws or policy that will necessitate additional training of staff.
7. Supervisors and employees shall be responsible for identifying the availability of specific educational opportunities.
8. Individual training needs shall be reviewed at least annually at the time of employee performance evaluation.

Continuing Education Requests/Documentation:

1. Each employee will maintain an annual continuing education log – see appendix. The employee will be responsible for providing the department supervisor and the Management Support Supervisor a copy of the log by January 31st for the previous calendar year.
2. Each employee will be responsible for notifying his/her department supervisor of annual educational requirements for the person's position. This includes:

   A. The number of required educational contact hours per year.
   B. Any required educational session(s) or workshops that are mandated for the position.

3. Each employee will notify his/her supervisor of these requirements at the beginning of each fiscal year.
4. Each employee will be responsible for notifying his/her department supervisor of the date and time of educational offerings. These may include, but not be limited to:

   A. In-house inservices/educational sessions
   B. Sessions that require travel
   C. Online courses
   D. Webinars

5. Each employee will be responsible for:

A. Completing any required registration forms
B. Completing any required travel requests, including attaching the information regarding the continuing education offering with agenda
C. Completing any required Purchase Orders/Check Requests

6. The department supervisor will review the request for continued education and will:

A. Approve the request and forward to fiscal and the health director for approval

OR

B. Not approve the request and notify the staff member that the request has been denied.

7. Request Procedure for Out-of-House Continuing Education:

A. The employee will complete a travel request with an attachment describing the educational offering and place in his/her department supervisor's mailbox. The attachment must include:

1. Location of educational offering
2. Cost of educational offering
3. Number of continuing educational contact hours
4. Description of the educational offering
5. Agenda for the educational offering

B. The Department Supervisor will review the request and, if approved, will forward the request to fiscal staff. If not approved, the supervisor will return the denied request to the employee's mailbox.
C. Fiscal staff will review the request and provide fiscal approval.
D. After approval by the fiscal department, the request will be forwarded to the Health Director for final approval.
E. When the Health Director provides final approval, copies of the approved request will be placed in the employee's and department supervisor's mailboxes, notifying them of the approved request.
F. Once the approved travel request has been received by the employee, he/she will then complete:

1. Course registration as needed
2. Hotel registration as needed
3. Any needed check requests/purchase orders for the costs of the course/hotel/other items.
4. All check requests must have an attachment that justifies explains the request for the check (i.e. cost of hotel room, cost of course, etc.), a copy of the agenda and a copy of the approved travel request.

G. The employee email the check request(s)/purchase orders to his/her department supervisor.
H. The supervisor will approve the request and forward to the fiscal department.
I. The fiscal department will complete all the forms needed for the requests and forward to the county fiscal department for disbursal to the appropriate agency.
J. The employee is responsible for notifying the department supervisor and the Fiscal Account Specialist if the offering is cancelled after any payments have been made. The Fiscal Account Specialist will be responsible for requesting refunding of any monies that have already been sent to pay for the course.
K. The employee is responsible for cancelling any hotel accommodations made.

8. Request Procedure for In-House Continuing Education:

A. The employee will notify his/her department supervisor in writing of the request to attend an in-house educational session. The session may be:

1. Inservice
2. Webinar
3. Conference Call
4. Online Course

B. The department supervisor will notify the employee in writing if the request is approved or not approved.
C. If approved, the department supervisor will arrange the employee's schedule to allow the employee time to complete the session and access to any equipment needed to allow participation in the session.

9. Educational/Training Certificates:

A. Each employee will provide proof of attendance at the educational session, such as a copy of any certificate received by attending an educational course to the department supervisor and the Management Support Supervisor.
B. The certificate or other proof provided will be used to indicate the number of educational contact hours or the type of educational course attended.
C. The department supervisor will review the certificate copy to ensure the course meets contact hours requirements, initial the copy, make any needed comments and place the copy back in the employee's mailbox.
D. The employee will place a copy of the certificate in the Management Support Supervisor's mailbox. The Management Support Supervisor will place the copy in the employee's personnel file.

Required Continuing Education:

Some State, health department or agency programs mandate continued education for staff to be able to deliver services and, if applicable, to maintain professional licensure. The Sampson County Health Department shall comply with these mandates; the following is mandated for all staff during orientation and annually as indicated. See "Agency Annual Education Requirements" below.

1. All staff:

    A. Incident Command System – ICS – Training
    B. OSHA Training
    C. Public Health Preparedness Training
    D. HIPAA
    E. Public Health Law
    F. Title VI/ADA/LEP/Cultural Competency/Health Disparities
    G. Title X Trainings to include:

        1. Title X Guidelines
        2. Sex/Human Trafficking
        3. Reporting Child Abuse Requirements
        4. Any other required Title X trainings as announced by the Office of Population Affairs (OPA), the CDC or the North Carolina Department of Public Health Women's Health Branch.

    NOTE: ***Environmental Health and WIC Staff are exempt from Title X Training.***

2. Public Health Nurses:

    Sampson County Health Department Public Health Nurses must maintain Continuing Competence as required by the Board of Nursing effective July 1, 2006 with a minimum of 15 hours of continuing education every two years.

3. Child Health Enhanced Role Nurse Screener:

    Enhanced Role Child Health Nurse Screeners must complete 10 hours of relevant continuing education, 50 patients and 100 hours of clinical practice by December 31st of each year.

4. STD Enhanced Role Nurse Screener:

    Must complete 10 hours of relevant continuing education and see 50 clients by December 31st annually.

5. Environmental Health Specialists:

   All Environmental Health Specialists must complete 15 hours of continued education approved by the NC State Board of Environmental Health Specialist Examiners by December 31st annually.

6. Nutritionists:

   A. Registered Dietitian Nutritionists must be incompliance with CDR and complete 75 CEUs associated with the Learning Plan goals and objectives; must be completed within five (5) years of plan submission.
   B. Nutritionists that are not RDs must have a minimum of 5 CEUs in nutrition field/breastfeeding per year.

Agency Annual Education Requirements:

Annual agency educational trainings are required for all staff to comply with State and/or Federal Mandates. Other trainings are required for all staff to review/update staff on agency/program policies. These include, but are not limited to:

1. OSHA/ Bloodborne Pathogens/Respiratory Protection
2. Health Insurance Portability & Accountability Act – HIPAA
3. Title X Competency Trainings (EH & WIC Exempt)
4. CPR/AED for clinical staff and nurses
5. Customer Service/Patient Satisfaction
6. Incident Command System – ICS/NIMS Courses
7. Violence in the Workplace
8. Public Health Law
9. Cultural Competency and Sensitivity
10. OSHA/Fire and Safety/Emergency Action Plan
11. American Disabilities Act
12. Title VI/Disabilities/Limited English Proficiency
13. Health Disparities

References:

Occupational Safety and Health Act, Effective 1972 - OSHA
Health Insurance Portability and Accountability Act, Effective 1996 - HIPAA
Clinical Laboratory Improvement Act - CLIA
Americans With Disabilities Act - ADA
Civil Rights Act, Title VI, Effective 1964
North Carolina General Statute 130A
10A NCAC 46.0300 – .0301
Office of Public Health Preparedness and Response Agreement Addendum
NC DHHS Environmental Health Section Agreement Addendum
Federal Emergency Management Agency – FEMA
National Incident Management System – NIMS
North Carolina Annual Consolidated Agreement
State of North Carolina General Statutes
Sampson County Personnel Policy
American Heart Association CPR Training