NACA

NATIVE AMERICANS
FOR COMMUNITY ACTION

BOARD MEETING PACKET

May 20, 2026

NACA Main Office
1500 E. Cedar Ave., Suite 56
Flagstaff, Az. 86004
Phone: (928) 526-2968 Fax: (928) 526-0706

NACA Family Health & Wellness Center
1500 E. Cedar Ave., Suite 26 & 52
Flagstaff, Az. 86004
Phone: (928) 773-1245 Fax: (928) 773-9429

AGENDA

Monthly Meeting of Board of Directors
In-Person Meeting at Hopi Room
May 20, 2026 at 5:30 p.m.

AGENDA

Notice is hereby given to the members of the Board of Directors and to the public that the Board of Directors, Native Americans for Community Action, Inc. will hold a Board Meeting. The Native Americans for Community Action, Inc. Board of Directors may vote to go into Executive Session, which will not be open to the public, to discuss certain matters.

Call to Order: PM on May 20, 2026

REGULAR MEETING

Roll Call: Board Members

Liv Knoki, President	Juliette Roddy, Vice-President	Vacant, Treasurer
Vacant, Secretary	Charles Doughty	Victoria Tewa
Rachael Baker	Melinda Smith	Skyler Bordeaux

NACA Mission Statement:
The mission of Native Americans for Community Action, Inc. is to provide preventative wellness strategies, empower, and advocate for Native people and others in need to create a healthy community based on Harmony, Respect, and Indigenous Values.

1. **Prayer** –

2. **Agenda** – Adoption of the agenda, as submitted, is recommended. (ACTION)

   May 20, 2026 Board Agenda

3. **Minutes** – Approval of Minutes (ACTION) – Estimate 3 minutes:

   February 25, 2026 Board Minutes
   April 15, 2026 Board Minutes

4. **Public Participation (limited to 3 minutes)**

5. **Announcements** (NON-ACTION) – New Staff

6. **Consent Items** (ACTION/NON-ACTION)
   Items for consideration, discussion, and possible approval. Items on consent agenda are considered routine and unless otherwise indicated, expenditures approved by the Board are budgeted items.

A. Review and Approval of Policies & Procedures (ACTION) – Francisco Rendon
  - Review: IC 100 Infection Control Program Policy
  - Review: IC 110 Bloodborne Pathogens Exposure Policy
  - Review: IC 120 Communicable Disease Reporting
  - Review: IC 130 Post Exposure Prophylaxis to Prevent Transmission of HIV
  - Review: IC 140 Isolation of Patient or Client
  - Revision: IC 150 Outbreak Investigation, Influx Infectious Patients
  - Review: IC 160 Respiratory Protection Policy (Tuberculosis)
  - Review: IC 170 Universal and Transmission Based Precautions
  - Review: IC 180 Medical Sharps
  - Review: IC 200 Hand Hygiene Policy
  - Review: IC 210 Employee Vaccination Policy
  - Review: IC 230 Food and Drink in Patient Care Areas
  - Review: IC 300 Handling/Disposal of Biohazard Waste
  - Review: IC 310 Housekeeping and Custodial Services Policy
  - Review: IC 320 Cleaning and Disinfecting Patient Care Equipment
  - Review: IC 330 Infection Control for Cleaning & Intermediate-Level Disinfection
  - Review: IC 340 Infection Control for Construction and Maintenance
  - Review: IC 400 Food and Nutrition Services
  - Revision: IC 410 Service Animal Accommodation for Patients
  - Review: LS 200 Laboratory Quality Control Equipment Testing
  - Revision: LS 210 Specimen and Biological Product Handling Policy
  - Revision: LS 220 Emergency Laboratory Testing
  - Infection Prevention and Control Program 2026

B. Review and Approval of Policies & Procedures (ACTION) – Cynthia Little
  - Revision: HR 419 Early Identification, Assessment, and Management of Suicide Risk
  - New: VFP 100 Use of Motor Vehicle
  - New: VFP 200 Fleet Fuel Card Usage

C. NACA Logo Package (ACTION) – Almalia Berrios

7. <u>Regular Items</u> (ACTION/NON-ACTION)

A. Financial Report:
  - Financial Updates (NON-ACTION)

B. CEO/NACA Program Reports (NON-ACTION)

8. <u>Old Business</u>

A. Physician Recruitment (NON-ACTION)
  - Dr. Nelson

9. <u>New Business</u>

<u>Next Board Meeting Date:</u> June 17, 2026 at 5:30 p.m.

Adjournment of Meeting:

MEETING MINUTES
FEBRUARY 25, 2026
APRIL 15, 2026

Monthly Meeting of Board of Directors
In-Person Meeting at Hopi Room
February 25, 2026 at 5:30 p.m.

MEETING MINUTES

Notice is hereby given to the members of the Board of Directors and to the public that the Board of Directors, Native Americans for Community Action, Inc. will hold a Board Meeting. The Native Americans for Community Action, Inc. Board of Directors may vote to go into Executive Session, which will not be open to the public, to discuss certain matters.

Call to Order: 5:40 PM by Board President Liv Knoki.

REGULAR MEETING

Roll Call: Board Members P/NP/E

Liv Knoki, President – P
Vacant, Secretary
Rachael Baker – P
Juliette Roddy, Vice-President – P
Charles Doughty – P
Melinda Smith – P
Vacant, Treasurer
Victoria Tewa – P

NACA Mission Statement:
The mission of Native Americans for Community Action, Inc. is to provide preventative wellness strategies, empower, and advocate for Native people and others in need to create a healthy community based on Harmony, Respect, and Indigenous Values.

1. **Prayer** – Offered by Christopher David.

2. **Agenda** – Adoption of the agenda, as submitted, is recommended. (ACTION)

   February 25, 2026 Board Agenda

   *Motion to **adopt and approve** with edited rescheduled board meeting date.*
   Motion: Rachael Baker Second: Juliette Roddy
   Yes: 5 No: 0 Abstain: 0

3. **Minutes** – Approval of Minutes (ACTION) – Estimate 3 minutes:

   January 21, 2025 Board Minutes

   *Motion to **adopt and approve** as provided.*
   Motion: Juliette Roddy Second: Rachael Baker
   Yes: 5 No: 0 Abstain: 0

4. **Public Participation (limited to 3 minutes)**

No public participation.

5. **Announcements** (NON-ACTION) – New Staff

1) Douglas Griffin – Patient Services Coordinator
2) Esther Dreher – Advanced Practice Provider (Psychiatric)

6. **Consent Items** (ACTION/NON-ACTION)
Items for consideration, discussion, and possible approval. Items on consent agenda are considered routine and unless otherwise indicated, expenditures approved by the Board are budgeted items.

A. Justification for Approval to Purchase Influenza Vaccines (ACTION) – Verity Quiroz

*Motion to **adopt and approve** as provided.*
Motion: Rachael Baker Second: Victoria Tewa
Yes: 5 No: 0 Abstain: 0

B. Review and Approval of Policies & Procedures (ACTION) – Verity Quiroz
- Revision: HP 100 Health Promotion Program Services Policy
- Revision: HP 110 Patient Referrals to Health Promotion Program Services
- Review: HP 120 Initial Health Needs Evaluation for Health Promotion Services
- Review: HP 130 Health Education and Health Coaching
- Review: HP 140 Diabetes Education Curriculum
- Revision: HP 150 Community Health Representative Program
- Review: HP 160 Health Promotion Program Evaluator Policy
- Review: HP 170 Medical Nutrition Therapy Program Policy
- Review: HP 180 Fitness Specialist Program Policy
- Review: HP 200 Health Promotion Patient/Client Registries

*Motion to **adopt and approve** as provided.*
Motion: Juliette Roddy Second: Rachael Baker
Yes: 5 No: 0 Abstain: 0

C. Consent to Treat Form for FHC and BH (ACTION) – Darlene Schuster

*Motion to **adopt and approve** as provided.*
Motion: Rachael Baker Second: Juliette Roddy
Yes: 5 No: 0 Abstain: 0

D. Review and Approval of Policies & Procedures (ACTION) – Walter McCullough
- Revision: FIN 9.0 Fees & Collections

*Item was **adopted and approved** February 19th, 2026 through e-vote.*

E. Justification for Approval to Purchase Laptops for FHC and BH (ACTION) – Walter McCullough

*Motion to **adopt and approve** on contingent IHS laptops for Dell laptops beginning March 6th, 2026.*

Motion: Rachael Baker   Second: Juliette Roddy
Yes: 5   No: 0   Abstain: 0

7. **Regular Items** (ACTION/NON-ACTION)

A. Financial Report:
- Financial Updates (NON-ACTION)

B. CEO/NACA Program Reports (NON-ACTION)

8. **Old Business**

A. Physician Recruitment (NON-ACTION)
- Dr. Nelson – candidate
- Dr. Harwood – candidate
- Ruth DeBoard, Advanced Practice Provider – licensing

9. **New Business**

Next Board Meeting Date: March 18, 2026 at 5:30 PM

Adjournment of Meeting: February 25, 2026 at 7:01 PM

Monthly Meeting of Board of Directors
In-Person Meeting at Hopi Room
April 15, 2026 at 5:30 p.m.

MEETING MINUTES

Notice is hereby given to the members of the Board of Directors and to the public that the Board of Directors, Native Americans for Community Action, Inc. will hold a Board Meeting. The Native Americans for Community Action, Inc. Board of Directors may vote to go into Executive Session, which will not be open to the public, to discuss certain matters.

Call to Order: 5:30 PM by Board President Liv Knoki.

REGULAR MEETING

Roll Call: Board Members P/NP/E

Liv Knoki, President – P	Juliette Roddy, Vice-President – P	Vacant, Treasurer
Vacant, Secretary	Charles Doughty – P	Victoria Tewa – E
Rachael Baker – P	Melinda Smith – E	

NACA Mission Statement:
The mission of Native Americans for Community Action, Inc. is to provide preventative wellness strategies, empower, and advocate for Native people and others in need to create a healthy community based on Harmony, Respect, and Indigenous Values.

1. **Prayer** – Offered by Christopher David.

2. **Agenda** – Adoption of the agenda, as submitted, is recommended. (ACTION)

   April 15, 2026 Board Agenda

   *Motion to **adopt and approve** with edited rescheduled board meeting date.*
   Motion: Charles Doughty Second: Juliette Roddy
   Yes: 4 No: 0 Abstain: 0

3. **Minutes** – Approval of Minutes (ACTION) – Estimate 3 minutes:

   No Board Minutes

4. **Public Participation (limited to 3 minutes)**

   No public participation.

5. Announcements (NON-ACTION) – New Staff

1) Jensen Lanza – Grand Canyon Ranger
2) Tyrell Tsinnie – Grand Canyon Ranger
3) Cassie Webster – Health Information Specialist
4) Ruth DeBoard – Advanced Practice Provider
5) Kendra Gillman – Certified Medical Assistant
6) Kyte Castillo – Health Information Systems Specialist

6. Consent Items (ACTION/NON-ACTION)

Items for consideration, discussion, and possible approval. Items on consent agenda are considered routine and unless otherwise indicated, expenditures approved by the Board are budgeted items.

A. Review and Approval of Polices & Procedures (ACTION) – Verity Quiroz

- New: MS 970 Medication, Medical Supply, Medical Equipment Procurement

Motion to ***adopt and approve*** *as provided.*
Motion: Charles Doughty Second: Juliette Roddy
Yes: 4 No: 0 Abstain: 0

B. Review and Approval of Policies & Procedures (ACTION) – Francisco Rendon

- Revision: AG 100 Mission, Vision, & Values
- Revision: AG 110 Scope of Services (Program Descriptions)
- Revision: AG 120 Days & Hours of Operation
- Review: AG 121 After Hours Coverage
- Review: AG 130 Organizational Structure & Management Responsibilities
- Review: AG 131 Management Travel
- Review: AG 200 Policy and Procedure Development and Maintenance
- Review: AG 300 Compliance Program Policy
- Review: AG 310 Compliance Program Training and Education
- Review: AG 320 Reporting Instances of Non-Compliance and Non-Retaliation
- Review: AG 321 Responding to Allegations Made Against the CEO
- Revision: AG 350 Legal Counsel
- Revision: AG 400 Marketing, Advertising, and Media Release
- Revision: HIPAA 100 Health Insurance Portability and Accountability Act (HIPAA)
- Revision: HIPAA 110 Access to Protected Health Information by an Individual Receiving Services
- Review: HIPAA 130 Accounting to Disclosure of Protected Health Information
- Revision: HIPAA 150 Authorization Not Required
- Review: HIPAA 160 Minimum Necessary
- Revision: HIPAA 170 De-Identified Protected Health Information
- Revision: HIPAA 180 Addressing Business Associate Relationships
- Review: HIPAA 1120 Notice of Privacy Practices
- Revision: HIPAA 1130 Complaints
- Review: HIPAA 1160 Documentation
- Revision: HIPAA 1220 Managing Marketing Activities
- Revision: RR 100 Patient/Client Rights and Responsibilities
- Revision: RR 110 General and Informed Consent for Treatment
- Review: RR 120 Patient/Client Complaints & Grievances

- Review: RR 130 HIPAA Notice of Privacy Practices
- Revision: RR 140 Advance Directive/Power of Attorney
- Revision: RR 150 Disruptive Behavior, Patient
- Review: RR 200 Child Abuse/Neglect Reporting
- Review: RR 210 Adult Abuse/Neglect Reporting
- Review: RR 300 Treatment of Minors
- Review: RR 310 Minors Accompanying Patients/Clients
- Revision: RR 400 Interpretive Services for Health Impaired & Non-English-Speaking Patients/Clients
- Revision: RR 420 Rescheduled, Missed, or Canceled Appointments
- Review: EOC 100 Fire Safety Management Plan
- Review: EOC 200 Facility and Environmental Safety
- Review: EOC 210 Chemical Handling and Storage
- Review: EOC 220 Biological Hazards and Bioterrorism Policy
- Review: EOC 230 Medical Equipment Standardization & Maintenance
- Review: EOC 240 Policy for Monitoring and Disposal of Clinical Medications, Reagents, Solutions, and Supplies
- Review: MM 200 Medication Oversight
- Review: MM 210 Medication Administration
- Revision: MM 220 Multiple-Dose Vials (MDV)
- Revision: MM 230 High Alert and Hazardous Medication Policy
- Revision: MM 240 Look Alike/Sound Alike Medication Policy
- Review: MM 250 Medication Use During Invasion Procedures Policy
- Revision: MM 260 Pediatric Verification Policy of Administration of Vaccines or Medication
- Review: MM 270 Medication Use During Invasion Procedures Policy
- Review: MM 300 Vaccine Management, Administration, and Disposal Policy
- Revision: MM 310 Vaccine Temperature Excursion Policy
- Review: MM 400 Acceptable Medication Order Types Policy
- Revision: MM 410 Electronic Prescribing System Security and Access Control
- Review: MM 420 Medical Reconciliation
- Review: MM 430 Medication Refills
- NACA Community Emergency Response Plan
- NACA Emergency and Disaster Response Plan
- NACA Emergency Operations Plan
- NACA Safety and Emergency Management Program
- Hazard Vulnerability Assessment – Annual Review

*Motion to **adopt and approve** as provided.*
Motion: Juliette Roddy Second: Charles Doughty
Yes: 4 No: 0 Abstain: 0

C. NACA Logo Package (ACTION) – Almalia Berrios

Motion to table NACA Logo Package until further notice.

D. E-Vote: FIN 9.0 Sliding Scale Fee Schedule Policy, Approved 03/16/26 (ACTION) – Walter McCullough

E. E-Vote: NACA 403(b) Transition, Approved 03/16/26 – Cynthia Little

7. Regular Items (ACTION/NON-ACTION)

A. Financial Report:
   - Financial Updates (NON-ACTION)

B. CEO/NACA Program Reports (NON-ACTION)

C. Finance Committee (NON-ACTION) – April 3, 2026

8. Old Business

A. Physician Recruitment (NON-ACTION)
   - Dr. Nelson – signed official offer letter
   - Dr. Farrag – interviewed 03/16/26, 4th Provider

9. New Business

Next Board Meeting Date: May 20, 2026 at 5:30 PM

Adjournment of Meeting: April 15, 2026 at 7:14 PM

CONSENT ITEMS

NACA
NATIVE AMERICANS
FOR COMMUNITY ACTION

Infection Control (IC) Policies

Annual Review Details — May 2026

Reviewed by: Francisco Rendon, QI & Compliance Director

Annual Review Date: May 20, 2026 | Effective Date: May 21, 2026

Overview

The following Infection Control (IC) policies were reviewed as part of the May 2026 annual policy review cycle. Two policies received substantive revisions requiring Board of Directors approval. All other IC policies were reviewed and required no substantive changes.

Policies Requiring Revision

IC 150 — Outbreak Investigation, Influx Infectious Patients

Change:

Added language requiring that following an outbreak or influx event, a post-event evaluation shall be conducted and incorporated into Quality Improvement activities.

Rationale:

AAAHC standards and IHS Infection Control guidelines require that quality-relevant events -- including infectious disease outbreaks -- be systematically reviewed to identify trends, contributing factors, and opportunities for improvement. While NACA's existing policy outlined immediate response steps for outbreak events, it lacked a formal requirement to evaluate the event after resolution. Adding this language closes that gap by ensuring that every outbreak or influx event generates a documented, QI-integrated review. This supports both continuous improvement and provides the kind of evidence trail expected during accreditation review, demonstrating that the organization learns from and responds to infection control events rather than simply managing them in the moment.

IC 410 — Service Animal Accommodation for Patients

Change:

Added a new "Environmental Cleaning" section requiring that areas occupied by service animals be cleaned and disinfected after the visit, as appropriate.

Rationale:

The Americans with Disabilities Act (ADA) requires healthcare settings to accommodate service animals in all patient care areas. However, this accommodation must be balanced against infection control obligations. AAAHC Environment of Care standards and CDC infection prevention guidance require that patient care areas be maintained in a clean and sanitary condition. The addition of an explicit post-visit cleaning requirement addresses the intersection of ADA compliance and infection control -- acknowledging that service animals are permitted while ensuring that their presence does not compromise the cleanliness of the clinical environment. This language is consistent with how peer FQHCs and IHS-affiliated organizations handle service animal accommodation within infection control frameworks.

Policies Reviewed — No Substantive Changes

The following IC policies were reviewed and required no substantive changes. Dates, approval, and effective dates have been updated to reflect the May 2026 annual review cycle.

Policy	Policy Name

IC 100	Infection Control Program Policy
IC 110	Bloodborne Pathogens Exposure Policy
IC 120	Communicable Disease Reporting
IC 130	Post Exposure Prophylaxis to Prevent Transmission of HIV
IC 140	Isolation of Patient or Client
IC 160	Respiratory Protection Policy (Tuberculosis)
IC 170	Universal and Transmission Based Precautions
IC 180	Medical Sharps
IC 200	Hand Hygiene Policy
IC 210	Employee Vaccination Policy
IC 230	Food and Drink in Patient Care Areas
IC 300	Handling/Disposal of Biohazard Waste
IC 310	Housekeeping and Custodial Services Policy
IC 320	Cleaning and Disinfecting Patient Care Equipment
IC 330	Infection Control for Cleaning & Intermediate-Level Disinfection
IC 340	Infection Control for Construction and Maintenance
IC 400	Food and Nutrition Services

List of Infection Control (IC) Policies:

IC 100 Infection Control Program Policy
IC 110 Bloodborne Pathogens Exposure Policy
IC 120 Communicable Disease Reporting
IC 130 Post Exposure Prophylaxis to Prevent Transmission of HIV
IC 140 Isolation of Patient or Client
IC 150 Outbreak Investigation, Influx Infectious Patients
IC 160 Respiratory Protection Policy (Tuberculosis)
IC 170 Universal and Transmission Based Precautions
IC 180 Medical Sharps
IC 200 Hand Hygiene Policy
IC 210 Employee Vaccination Policy
IC 230 Food and Drink in Patient Care Areas
IC 300 Handling/Disposal of Biohazard Waste
IC 310 Housekeeping and Custodial Services Policy
IC 320 Cleaning and Disinfecting Patient Care Equipment
IC 330 Infection Control for Cleaning & Intermediate-Level Disinfection
IC 340 Infection Control for Construction and Maintenance
IC 400 Food and Nutrition Services
IC 410 Service Animal Accommodation for Patients

POLICY: IC 100	(X) Revision ( ) New	Original Issue Date: 03/24/17 Revised Date: 07/06/22; 05/07/24 Approved by: Board of Directors Approval Date: 07/20/22; 05/15/24; 05/21/25; 5/2026 Effective Date: 07/21/22; 05/16/24; 05/22/25; 5/21/26 Annual Review Date: 5/1/26
Infection Control Program Policy	Author: QI & Compliance Director	

I. **POLICY:** Native Americans for Community Action, Inc. (NACA) has an infection control plan to prioritize risk of spread of infectious diseases and mitigate such risks.

II. **PURPOSE:** The purpose of the NACA Infection Control Plan is to minimize the risk of spreading infections through an Infection Control Program.

III. **PROCEDURE:**

A. Components of the Infection Control Program will address the following:
- Introduction
- Structure and Authority
- Reporting Structure
- Risk Assessment
- Program Goals
- Surveillance Plan
- Responsibilities of the program
- Education
- Influx
- Outbreak Investigation
- Infectious Waste
- Transmission Based Precautions
- Respiratory Hygiene
- Infectious Based Transfers
- Cleaning and Disinfection
- Employee Health
- Construction and Renovation Environmental Services
- Annual Evaluation

B. References
- NACA will consult reliable resources for use in infection control policies, procedures, and program including but not limited to:
  1. Center for Disease Control (CDC)
  2. World Health Organization (WHO)
  3. Association for Professionals in Infection Control and Epidemiology (APIC)

POLICY: IC 110	(X) Revision ( ) New	Original Issue Date: 03/24/17 Revised Date: 07/06/22; 05/07/24; 5/13/26 Approved by: Board of Directors Approval Date: 07/20/22; 05/15/24; 05/21/25; 5/20/206 Effective Date: 07/21/22; 05/16/24; 05/22/25; 5/21/26 Annual Review Date: 05/1/26
Bloodborne Pathogens Exposure Policy	Author: QI & Compliance Director	

I. **POLICY:** The policy of NACA is to provide a safe and healthy work environment for employees in protecting healthcare workers from bloodborne pathogen exposure.

II. **PURPOSE:** To provide healthcare workers with updated information on the management of persons with occupational exposure to bloodborne pathogens. To prevent or reduce the risk of transmission of bloodborne pathogens after exposure.

III. **PROCEDURE:** To document the route of exposure and how the exposure occurred. Identify and document the source individual (unless the employer can establish that identification is infeasible or prohibited by state or local law).

A. Staff Education: Staff shall receive training on bloodborne pathogens upon hire and annually thereafter. Training shall include at a minimum:
- Definition of a bloodborne pathogen exposure.
- Standard/Universal and Transmission Based Precautions.
- Identification of potential bloodborne pathogen exposure.
- The use of personal protective equipment during potential bloodborne pathogen exposure.
- Education on Hepatitis B vaccination.
- Post bloodborne exposure follow up.

B. Procedural Risk: The following procedures are identified as a potential source of exposure to bloodborne pathogens:
- HgA1C point of care testing
- Glucose point of care testing
- PT/INR point of care testing
- Cholestatic point of care testing
- Other laboratory procedures including specimen collections
- Intradermal, Subcutaneous, Muscular, and Joint Injections
- Wound cleaning and dressing changes
- Minor Invasive Procedures
- Cleaning of blood spills
- Handling of Biohazardous Waste

C. Job Description Risk: The following job descriptions are identified as higher risk for exposure to bloodborne pathogens:
- Physician

- Nurse Practitioner
- Nurse
- Medical Assistant
- Dietitian
- Health Educator
- Housekeeper

D. Consent: The employee and source patient maintain the right to refuse bloodborne pathogen testing. Acceptance or Rejection of testing shall be documented. Source patients and employee HIV test results and related information are confidential.

E. Employee Follow-up: NACA shall provide, at no cost, evaluation, and treatment of post bloodborne pathogen exposure. The employee has the right to consent or decline blood testing including Human Immunodeficiency Virus, Hepatitis B and Hepatitis C Virus. The employee has the right to review the result of the source patient results with consent. Confidential Medical records are maintained in the Employee Medical Record housed in Medical Records. The employee can be provided with the records upon request with written consent.

F. Exposure Incident Evaluation: The Infection Control Coordinator will record the incident in the Sharps Injury Log or submit an incident report to the Quality Improvement and Compliance Director (if not sharps related). The Infection Control Coordinator and Quality Improvement and Compliance Director will review the circumstances of the exposure including:

- Workplace practices
- A description of the procedure
- A description of the device as applicable
- Personal Protective Equipment used
- Location of Incident
- Review of affected employee's training

POLICY: IC 120	(X) Revision ( ) New	Original Issue Date: 03/09/05 Revised Date: 09/20/21; 05/07/24 Approved by: Board of Directors Approval Date: 10/16/21; 05/15/24; 05/21/25; 5/20/26 Effective Date: 10/17/21; 05/16/24; 05/22/25; 5/21/26 Annual Review Date: 05/1/26
Communicable Disease Reporting	Author: QI & Compliance Director	

I. **POLICY:** The policy of NACA is to report suspected and/or confirmed cases of communicable disease to the Coconino County Health Department (CCHD) and/or ADHS to receive advice, guidance, and epidemiological assistance in the treatment of cases, controlled epidemics, and in tracing the origin and mode of the spread of disease.

II. **PURPOSE:** To ensure monitoring and reporting suspected and/or confirmed cases of communicable disease is completed per AAC Title 9, Chapter 6.

III. **DEFINITIONS:**

Outbreak: An unexpected increase in incidence of a disease, infestation, or sign or symptom of illness.

Post-Exposure Prophylaxis: Treatment provided to an individual who may have been exposed to a communicable disease, which is intended to prevent infection of the individual.

ADHS: Arizona Department of Health Services

CCHD: Coconino County Health Department

IV. **PROCEDURE:**

A. All diseases listed on the ADHS List of Reported Diseases (APPENDIX I) shall be reported within the identified time frames to the CCHD and/or ADHS as required by Arizona Administrative Code R9-6-202.

B. The individual who identifies a suspected or confirmed case of reportable communicable disease shall notify the Medical Director and/or the RN and initiate the procedure as referenced in the Isolation of Patient/Client policy.

C. If employees, other patients/clients, visitors, or guests may have been exposed, appropriate post-exposure prophylaxis and testing shall be initiated.

D. There are two (2) options for reporting diseases to the CCHD and ADHS:
- Written report using the ADHS reporting form (APPENDIX II) may be faxed to (928) 679-7351.
- Online report via MEDIS: https://www.connect.azdhs.gov.

E. The report is filed and tracked by the Infection Control Officer, who shall submit a quarterly report to the Quality Improvement Committee of all cases or suspect cases of communicable diseases diagnosed, treated, or detected.

NACA
NATIVE AMERICANS FOR COMMUNITY ACTION

POLICY: IC 130	( ) Revision (X) New	Original Issue Date: 05/01/24 Revised Date: Approved by: Board of Directors Approval Date: 05/15/24; 05/21/25; 5/20/26 Effective Date: 05/16/24; 05/22/25; 5/21/26 Annual Review Date: 05/1/26
Post Exposure Prophylaxis to Prevent Transmission of HIV	Author: QI & Compliance Director	

I. **POLICY:** The policy of NACA is to provide evaluation and treatment of healthcare workers who are exposed to human immunodeficiency virus (HIV).

II. **PURPOSE:** To provide healthcare workers with updated information on the management of persons with occupational exposure to HIV. To prevent or reduce the risk of transmission of HIV after exposure to the virus(es).

III. **PROCEDURE:**

A. Incident Reporting: Document the route of exposure and how the exposure occurred. Identify and document the source individual (unless the employer can establish that identification is infeasible or prohibited by state or local law).

B. Category: Evaluating healthcare workers following occupational exposure requires an assessment of both the nature of the exposure and the likelihood that the source patient is HIV-infected.

Category	Description
Category 1	The source patient is known or unknown HIV+ with one or more symptoms associated with active HIV infection and the incident involved blood, or body fluids contaminated with visible blood, or a laboratory specimen containing HIV from the source patient in any of the following circumstances: injection via needlestick or deep laceration, exposure that is prolonged or that which involves an extensive area of damaged skin, contact with mucous membrane(s).
Category 2	The source patient is known HIV (+) with no symptoms of HIV disease or is at high-risk for having positive HIV antibody test and the incident involved blood or body fluids to which universal precautions apply from the source patient in any of the following circumstances: superficial abrasion via needle stick, without fluid being injected into the employee or minimal exposure of damaged skin.
Category 3	The source patient has no risk factor for HIV, but the incident involved exposure to the blood and body fluids of the patient.

C. Treatment: The following recommendations should be implemented after consultation with a physician having expertise in antiretroviral therapy and HIV Transmission.

- Chemoprophylaxis should be recommended to exposure workers and occupational exposure associated with the highest risk for HIV transmission category. For exposures with a lower, but non-negligible risk, post exposure prophylaxis (PEP) should be offered, balancing the lower risk against the use of drug having uncertain efficacy and toxicity. For exposures with negligible risk, PEP is not justified.

- For HIV strains suspected to be resistant to both AZT and 4TC or resistant to a protease inhibitor, or if these drugs are contraindicated or poorly tolerated, the optimal PEP regimen is uncertain and further expert consultation is advised.
- PEP should be initiated promptly, ideally within one hour and no later than 36 hours post exposure. PEP should be administered for four weeks.
- If the source patient or the patient's HIV status is unknown, PEP initiation should be decided on a case-by-case basis based on exposure risk and likelihood of infection is known. If additional information becomes available, a decision about PEP can be made.
- Workers with occupational exposure to HIV should receive follow up counseling and medical evaluation including HIV antibody test at baseline and periodically for at least 6 months post exposure (baseline, 6 weeks, 3 months, and 6 months even if PEP is declined) and should observe precautions to prevent secondary transmission. If PEP is used, drug-toxicity monitoring should include a CBC with differential and renal/hepatic function tests at baseline and 2 weeks after starting PEP. If subjective or objective toxicity is noted, dose reduction or drug substitution should be considered with expert consultation and further diagnostic studies may be indicated.
- Healthcare workers should be monitored weekly while on PEP to assess treatment adherence, adverse effects, complaints, and emotional status.

D. <u>Consent:</u> The employee and source patient maintain the right to refuse HIV testing. The employee may still receive PEP. Acceptance or Rejection of testing should be documented. Source patients and employee HIV test results and related information are confidential.

E. <u>Employee Follow-Up:</u> The employee will be scheduled for a follow up 1 week, 6 weeks, 3 months, and 6 months post incident. If the source patient is HIV (–) and not a high-risk patient, employee does not need to schedule after the second visit. Employees are asked to report as scheduled and for evaluations of any acute febrile illness that occurs within 12 weeks of the exposure, especially if the fever is accompanied by rash or lymphadenopathy. If the employee tests HIV (+) they will be given a list of resources for medical and psychiatric follow-up care and assistance with contacting appropriate care organizations. The employee has the right to review the result of the source patient results with consent. Confidential Medical records are maintained in the Employee Medical Record housed in Medical Records. The employee can be provided with the records upon request with written consent.

F. <u>Evaluation of the Exposure Incident:</u> The Infection Control Coordinator will record the incident in the Sharps Injury Log. The Infection Control Coordinator will review the circumstances of the exposure including:

- Workplace practices
- A description of the procedure
- A description of the device as applicable
- Personal Protective Equipment used
- Location of Incident
- Review of affected employee's training

POLICY: IC 140	(X) Revision ( ) New	Original Issue Date: 04/14/14 Revised Date: 09/20/21; 05/07/24; 05/05/25
Isolation of Patient or Client	Author: QI & Compliance Director	Approved by: Board of Directors Approval Date: 10/16/21; 05/15/24; 05/21/25; 5/20/26 Effective Date: 10/17/21; 05/16/24; 05/22/25; 5/21/26 Annual Review Date: 05/1/26

I. **POLICY:** The policy of NACA is to isolate suspected and/or confirmed cases of communicable disease to minimize the exposure to other patients, clients, employees, contractors, visitors, and guests.

II. **PURPOSE:** To minimize patient, client, employee, visitor, and guest exposure to communicable respiratory and contact diseases.

III. **PROCEDURE:**

A. The following communicable disease require patient/client isolation:
- Active tuberculosis
- Measles
- Meningococcal invasive disease
- Varicella (chicken pox)
- Any meningitis/encephalitis
- Pertussis
- Haemophilus influenza
- Diphtheria (respiratory)
- Plague (pneumonia)
- Pedicullosis (lice)
- Scabies; and
- Impetigo

B. If determined by telephone assessment a patient/client may have one of the listed diseases, the Medical Director, Rendering Provider, and/or the RN shall be notified and the patient/client shall be instructed to immediately identify themselves at the reception window upon arrival in order to be placed in the nearest available exam room with appropriate precautions (i.e. universal, contact, droplet, airborne).

C. If a walk-in patient/client presents at the reception window and it is determined the patient/client may have one of the listed diseases, the patient/client shall be directed to the nearest available exam room with appropriate precautions.

D. The exam room shall not be utilized until the room has had a terminal clean performed. A sign shall be posted on the exam room door indicating no entrance until the area has been cleaned and disinfected.

E. An Incident Report shall be completed and submitted within 24 hours per the Incident Reporting policy. If the disease is confirmed, a report shall be submitted to CCHD and/or ADHS by the Medical Director or designee.

POLICY: IC 150	(X) Revision () New	Original Issue Date: 07/31/23 Revised Date: 05/14/26 Approved by: Board of Directors ApprovalDate:05/15/24; 05/21/25; 5/20/26 Effective Date: 05/16/24; 05/22/25; 5/21/26 Annual Review Date: 05/1/26
Outbreak Investigation, Influx Infectious Patients	Author: QI & Compliance Director	

I. **POLICY:** The policy of NACA is to recognize a suspected fever/rash/cough illness that may indicate an outbreak or influx of infectious patients and should be immediately isolated, monitored, and tracked closely.

II. **PURPOSE:** To minimize the risk of transmitting infections during an unexpected increase in incidence of a disease, infestation, or sign or symptom of illness.

III. **PROCEDURE:**

A. In the event of an influx of infectious patients, the following steps shall be taken:
- A surgical mask should be immediately placed on patients presenting to the clinic with fever/rash/cough illness, travel history and escorted directly to an isolation room away from other patients and staff as best as possible pending clinical evaluation. These precautions may be discontinued once the medical evaluation has ruled out potentially communicable disease and the provider has issued further details on isolation precautions.
- Coconino County Health and Human Services should be consulted immediately for any patient deemed to be at moderate or high risk for highly contagious communicable disease (i.e., Ebola, smallpox, measles).
- Infection Control Personnel and NACA administrative staff should be immediately notified regarding the suspected case. Appropriate consultations should be requested from infectious disease specialists and dermatologists.
- A standardized isolation room sign noting the need for airborne and contact precautions should be displayed outside the patient's exam room.
- The door to the patient's room should remain closed.
- Personal protective equipment should be stocked outside the patient's room (i.e., gowns, gloves, masks, hoods, and booties)
- Minimize the number of person(s) who enter the patient's room as well as traffic into and out of the room. Visitors should be limited to immediate family who have already had contact with the patient prior to their arrival.
- Infection Control Staff shall track the names, job duty (for staff), home address, and all contact numbers for all clinic staff, visitors and others who entered the patient's room and had potential contact with the patient from the moment they entered the clinic.
- Care shall be taken when handling clinical laboratory specimens and requests should be limited to those tests that are essential to patient management. All clinical specimens should be doubled bagged, tightly sealed, and appropriately labeled prior to transport.
- Transfer to an appropriate care facility shall be arranged by the clinic staff and receiving organization should be made aware immediately of suspected diagnosis.

- Coconino County Health and Human Services shall be consulted if a trend of a similar illness is noted that may indicate an outbreak of infectious disease.
- Following an outbreak or influx event, a post-event evaluation shall be conducted and incorporated into Quality Improvement activities.

B. Resources:

- NACA shall utilize identified resources in the table below that can provide information on infections that could potentially cause an influx of infectious, or potentially infectious patients. Included among these are local, state, and federal public health systems. NACA will respond to an influx by following the NACA Emergency Response Plan for Emergency Disaster as initiated by an approved authority. NACA will activate and participate in the Community Disaster Response Plan, as applicable.

Resource	Telephone Number	Website
Coconino Community Health and Human Services	(928) 679-7272	Health and Human Services | Coconino (az.gov)
Arizona Department of Health Services	(602) 542-1025	Arizona Department of Health Services (azdhs.gov)
Navajo Nation Office of Environmental Health & Protection	(928) 871-6350	Office of Environmental Health & Protection (navajo-nsn.gov)
Centers for Disease Control and Prevention	1 (800) 232-4636	Centers for Disease Control and Prevention (cdc.gov)

C. Employee Infectious Disease Outbreak:

- In the event of an employee infectious disease outbreak, the following steps shall be taken:
    1. NACA staff will notify their immediate supervisor of illness.
    2. Supervisors will notify the Infection Control Coordinator if there are multiple employees out for the same type of illness.
    3. Infection Control Coordinator will provide education to NACA staff regarding illness that is trending on prevention, signs & symptoms, diagnosis, and treatment.
    4. Infection Control Coordinator will perform a focused risk assessment based on presentation of symptoms amongst staff.
    5. Infection Control Coordinator will consult Coconino Health and Human Services to assist leadership regarding recommendations on further actions if an outbreak is suspected.

POLICY: IC 160	( ) Revision (X) New	Original Issue Date: 07/31/23 Revised Date: 04/07/25 Approved by: Board of Directors Approval Date: 05/15/24; 04/16/25; 05/21/25; 5/20/26 Effective Date: 05/16/24; 04/17/25; 05/22/25; 5/21/26 Annual Review Date: 05/1/26
Respiratory Protection Policy (Tuberculosis)	Author: QI & Compliance Director	

I. **POLICY:** The policy of NACA is to recognize respiratory illness that may indicate infectious patients that require healthcare workers to use personal respiratory protection device(s) to prevent exposure to airborne contaminants.

II. **PURPOSE**: To prevent or minimize the risk of transmitting respiratory infections including tuberculosis by providing guidelines that ensure respiratory protection.

III. **PROCEDURE:** The primary objective is to prevent the transmission of respiratory infections including tuberculosis as recommended by the Center for Disease Control (CDC). The following steps shall be taken if in the presence of a known, or suspected respiratory illness, including Tuberculosis (TB):

A. Personal Protective Equipment – shall be required in the presence of a suspected respiratory illness, including tuberculosis. NACA shall provide and encourage:
- Proper and appropriate personal protective equipment.
- Frequent hand hygiene and provide adequate hand hygiene supplies.
- Social spacing from other person(s) in the vicinity.
- Visual alerts at the facility for patients and visitors to inform personnel of respiratory illness symptoms and to practice proper Respiratory Hygiene and Cough Etiquette.

B. Engineering Controls – where feasible, exposure to airborne contaminants will be removed by utilizing engineering controls such as local ventilation, HEPA filtration, and isolation.

C. Patient Measures – patients with signs and symptoms of respiratory infection shall:
- Cover nose and mouth when coughing/sneezing
- Use tissue to contain respiratory secretions and dispose of contaminated tissues in the nearest waste bin.
- Perform frequent hand hygiene especially after having contact with respiratory secretions or contaminated objects.
- Be encouraged to wear and offered a surgical mask.

D. Responsibilities:
- NACA will provide proper respiratory devices and PPE to meet the needs of each employee.
- Employees shall be provided with adequate training and instruction on all devices.
- Supervisors are responsible for ensuring that all personnel are trained in respiratory protection requirements and ensuring use of equipment in their respective departments.

- Employees shall be aware of the respiratory protection requirements for the areas in which they work. Employees are responsible for wearing the appropriate respiratory protection equipment according to proper use instructions.

E. Particulate Respirators shall be worn when:
- A patient is suspected or confirmed to have an active respiratory infection including active pulmonary or laryngeal tuberculosis.
- A patient is potentially infectious and is undergoing an exam or procedure that is likely to produce a burst of aerosolized infectious particles or to result in copious coughing or sputum production, regardless of whether appropriate ventilation is in place.

F. N95 Particulate Respirators – employees who enter a room with airborne precautions must wear an N95 Particulate Respirator that has been fit tested within the past year. Masks are to be kept outside of the patient room. The employee will inspect the respirator prior to use for defects or contamination.

G. Employee Medical Assessment – NACA staff are screened annually for tuberculosis (TB). Guidelines are as follows:
- New Hire 2 step Mantoux Skin Test (PPD) shall be conducted.
- Chest x-ray if positive PPD by history or on conversion from previous negative PPD.
- Assessment by Medical Staff for signs/symptoms of TB with known history of positive PPD with negative chest x-ray.
- Annual Screening Questionnaire to identify active TB signs/symptoms and follow up as indicated.
- NACA Infection Control will conduct an annual Facility Risk Assessment to evaluate appropriateness of screening process.

Possible or confirmed exposure to TB will be referred to the Coconino Health and Human services for monitoring and follow up. Employee Health will report any cases of PPD conversion to the Infection Control Committee.

H. Employee Fit Testing – employees with direct patient contact that require a respirator must be fitted and tested for a proper face seal. Fitting should be done upon hiring before the employee wears the mask and if there is a weight loss or gain of greater than 20 pounds. Employees who have excessive facial hair or whose facial features do not allow adequate seal, will not be fit tested.

POLICY: IC 170	(X) Revision ( ) New	Original Issue Date: 07/31/23 Revised Date: 05/07/24 Approved by: Board of Directors Approval Date: 05/15/24; 05/21/25; 5/20/26 Effective Date: 05/16/24; 05/22/25; 5/21/26 Annual Review Date: 05/1/26
Universal and Transmission Based Precautions	Author: QI & Compliance Director	

I. **POLICY:** The policy of NACA is to provide guidance to NACA staff for achieving safe and effective precautions to reduce and prevent the spread of infection through contact, droplet, and airborne exposure.

II. **PURPOSE:** To establish safety measures to reduce infection with transmission-based precautions and to ensure the safety of patients, staff, and visitors.

III. **DEFINITIONS:**

Universal or Standard Precautions: Standard precautions are meant to reduce the risk of transmission of bloodborne and other pathogens from both recognized and unrecognized sources. They are the basic level of infection control precautions which are to be used, as a minimum, in the care of all patients. (World Health Organization)

Contact Precautions: Contact Precautions are for patients with known or suspected infections that represent an increased risk for contact transmission. (Center for Disease Control)

Droplet Precautions: Droplet Precautions are for patients known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking. (Center for Disease Control)

Airborne Precautions: Airborne Precautions are for patients known or suspected of being infected with pathogens transmitted by the airborne route (i.e., tuberculosis, measles, chicken pox, disseminated herpes zoster). (Center for Disease Control)

Personal Protective Equipment (PPE): The main source of protection against biological hazards which include respirators, eye protection, hearing protection, and protective clothing (i.e., gloves, gowns, goggles, boots, respirators). (Center for Disease Control)

IV. **PROCEDURE:**

A. Universal or Standard Precautious Guidelines:
- Perform frequent hand hygiene.
- Ensure use of gloves, protective clothing, mouth/nose/eye coverings in situations involving possible contact with blood or body fluids, mucous membranes, or non-intact skin.
- Ensure appropriate respiratory hygiene/cough etiquette.
- Practice safe sharps work practices to reduce exposures to blood from sharp instruments and needles.

- Practice safe injection practices.

- Practice routine cleaning and disinfection of environmental surfaces.

B. Contact Precautions Guidelines:
- Continue to practice Standard Precautions.
- Ensure appropriate patient placement in a single room.
- Use PPE appropriately including gloves and gown. Wear a gown for all interactions that may involve contact with the patient or the patient's environment . Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain all pathogens.
- Limit transport and movement of patients outside of the room to medically necessary purposes. Cover or contain the infected areas of the patient's body.
- Use disposable or dedicated patient-care equipment (e.g., blood pressure cuffs). If common use of equipment for patients is unavoidable, clean and disinfect such equipment before use on another patient.
- Prioritize cleaning and disinfection of the rooms of patients on contact precautions ensuring rooms are frequently cleaned and disinfected focusing on frequently touched surfaces and equipment.

C. Droplet Precautions Guidelines:
- Continue to practice Standard Precautions.
- Ensure appropriate patient placement in a single room if possible. Place patients who require Droplet Precautions in an exam room as soon as possible and instruct patients to follow Respiratory Hygiene/Cough Etiquette recommendations.
- Use PPE appropriately. Don mask upon entry into the patient room or patient space.
- Limit transport and movement of patients outside of the room to medically necessary purposes. If transport or movement outside of the room is necessary, instruct patient to wear a mask and follow Respiratory Hygiene/Cough Etiquette.

D. Airborne Guidelines:
- Continue to practice Standard Precautions.
- Source control: Place mask on patient.
- Ensure appropriate patient placement in an airborne infection isolation room (AIIR) constructed according to the Guideline for Isolation Precautions. In settings where Airborne Precautions cannot be implemented due to limited engineering resources, masking the patient, and placing the patient in a private room with the door closed will reduce the likelihood of airborne transmission until the patient is either transferred to a facility with an AIIR or returned home.
- Restrict susceptible healthcare personnel from entering the room of patients known or suspected to have measles, chickenpox, disseminated zoster, or smallpox if other immune healthcare personnel are available.
- Use personal protective equipment (PPE) appropriately, including a fit-tested NIOSH-approved N95 or higher-level respirator for healthcare personnel.
- Limit transport and movement of patients outside of the room to medically necessary purposes. If movement outside an exam room is necessary, instruct patients to wear a surgical mask, if possible, and observe Respiratory Hygiene/Cough Etiquette.

- Immunize susceptible persons as soon as possible following unprotected contact with vaccine-preventable infections (e.g., measles, varicella, or smallpox).

E. Personal Protective Equipment – PPE shall be used for Standard and Transmission based precautions. NACA shall provide equipment and supplies to support the Infection Control Program at no cost to the employee. Types of PPE include:
   - Gloves
   - Gowns
   - Face shields or masks
   - Eye protection
   - Mouthpieces
   - Resuscitation bags
   - Pocket masks and other ventilation devices

F. Training – NACA shall provide the following training:
   - Use and limitations of PPE.
   - Types, locations, removal, handling, decontamination, and disposal of PPE.

POLICY: IC 180	(X) Revision ( ) New	Original Issue Date: 10/13/19 Revised Date: 09/20/21; 05/07/24 Approved by: Board of Directors Approval Date: 10/16/21; 05/15/24; 05/21/25; 5/20/26 Effective Date: 10/17/21; 05/16/24; 05/22/25; 5/21/26 Annual Review Date: 05/1/26
Medical Sharps	Author: QI & Compliance Director	

I. **POLICY:** It is the policy of NACA, in accordance with Occupational Safety and Health Administration OSHA and Center for Disease Control (CDC), to promote the safety of healthcare workers who handle sharps.

II. **PURPOSE:** To reduce the risk of bloodborne pathogen transmitted infections by providing guidelines for safe sharps handling and disposal.

III. **DEFINITIONS:**

Sharps: Items such as a needle, sharp edged instrument, broken glassware, razor, scalpel, or scissors.

Sharps Injury: An injury where a need or other sharp object, contaminated with blood or other bodily fluid penetrates the skin.

Safety Device: A physical attribute built into a needle device used for withdrawing body fluids, accessing a vein or artery, or administering medications or other fluids, which effectively reduces the risk of an exposure incident by a mechanism such as barrier creation, blunting, encapsulation, withdrawal or other effective mechanisms; Or By International Safety Center as adapted from the former International Healthcare Worker Safety Center at the University of Virginia A physical attribute built into any other type of needle device or into a non-needle sharp, which effectively reduces the risk of an exposure incident. (Center for Disease Control)

IV. **PROCEDURE:**

A. Strategies to Reduce and Eliminate Sharps Injuries: NACA will purchase (as available) sharps with safety devices such as retractable needles, needless systems, and sheaths/shields for needles, round tip blades, and blunt suture needles. NACA will consider the ease of use and reliability of product.

B. General Guidelines:
- Do not pass or transfer sharps.
- Do not recap contaminated sharps.
- Do not leave sharps in unusual places (counter, trays, exam table) or other surfaces. Be accountable for the sharps you use.
- Do not reach into a sharps container to retrieve any items.
- Do not bend or break needles or blades.
- Always maintain visual contact with sharps during use.

- Immediately place sharps into a sharp's disposable container.
- Report any injuries with sharps to your immediate supervisor and the Infection Control Coordinator.
- Prepare the device right before the moment of use.
- Be sure there is adequate lighting for visualization and available space for sharps use.
- Keep sharps pointed away from the user.
- Get assistance when using sharps with a confused or agitated patient.
- Dispose of syringes and needles as a single unit; do not remove the needle.

C. Disposal – NACA will provide OSHA approved medical sharps containers. Sharp containers will be mounted in any area where sharps would be used for patient care. Tabletop sharps containers shall not be used. When disposing of sharps, staff shall:

- Ensure lid is secured, container is mounted and locked in place before use.
- Sharps are never to be disposed of into a trash bag or receptacle.
- The container must be clearly labeled as a medical sharp's container or "biohazardous."
- Inspect that the sharps container is not more than ¾ full.
- Hands shall always be kept behind the sharp.
- Never place hands or fingers into a container to facilitate disposal of a device.
- The container must be out of reach of children and never placed on the floor or in high places.
- Ensure sharps containers are of an appropriate size for the clinical activity.
- Always carry a sharps container by the handle or use the carry tray provided for smaller containers. Never place it against your body.
- Ensure sharps containers are closed and locked before disposal and complete the closure label on the container.
- Do not place sharps containers in waste bags for disposal.
- Full, used sharps containers must be located away from patients and the public

D. Community Disposal: Puncture resistant medical sharps containers may be available for community use in common areas (i.e., front lobby). Medical sharps container must be mounted on the wall and secured by lock. The container must be clearly labeled as a medical sharp's container or "biohazardous".

NATIVE AMERICANS FOR COMMUNITY ACTION

POLICY: IC 200	(X) Revision ( ) New	Original Issue Date: 04/14/14 Revised Date: 09/20/21; 05/07/24 Approved by: Board of Directors Approval Date: 10/16/21; 05/15/24; 05/21/25; 5/20/26 Effective Date: 10/17/21; 05/16/24; 05/22/25; 5/21/26 Annual Review Date: 05/1/26
Hand Hygiene Policy	Author: QI & Compliance Director	

I. **POLICY:** The policy of NACA is to encourage patients, clients, employees, visitors, and guests to practice healthy hand hygiene to help prevent the spread of infection. Hand hygiene is the single most important strategy to reduce the risk of transmitting organisms from one person to another or from one site to another on the same patient.

II. **PURPOSE:** To decrease the risk of cross contamination between patients, clients, employees, care equipment, and the environment through hand hygiene.

III. **PROCEDURE:**

A. Training and Education – All employees will receive hand hygiene training and education upon hire, annually, and whenever deemed necessary.

B. General Guidelines:
- Clean hands before and after routine patient care activities, including entering and exiting the patient care environment and after hand-contaminating activities. Clean hands before and after handling medication or preparing food.
- Gloves do not replace the need for hand hygiene.
- Fingernails are to be kept neatly manicured, clean, and short (shall not extend past the tip of the finger). Artificial nails or enhancements are prohibited for employees who have direct patient contact, who prepare instruments for sterile procedures or who prepare sterile pharmaceuticals. Nail polish without embedded enhancements in good repair is permitted.
- Use alcohol gel for routine hand decontamination when hands are not visibly soiled.
- Use alcohol gel or antimicrobial soap for hand washing before invasive procedures such as immunizations or blood draws.
- Use soap and water hand washing for visibly soiled hands.
- Use soap and water hand washing after contact with patients with C. difficile or their environment.
- Antimicrobial-impregnated wipes (i.e., towelettes) are not as effective as (and are not a substitute for) alcohol-based hand rubs or washing hands with an antimicrobial soap and water.
- Avoid bar soaps.
- Use cassette-refillable dispensers. Do not refill or "top off" soap or gel cassettes, and do not use dispensers with refillable reservoirs. This practice can lead to bacterial contamination.

C. Hand Hygiene Indications – Key times to wash your hands include, but are not limited to:
- Before touching a patient
- Upon arrival to work

- Upon entry to an exam room
- Before patient/client contact, including dry skin contact
- Before contact with a wound
- Before donning gloves when providing direct patient care (wearing gloves does not substitute for hand hygiene)
- Before a clean/aseptic procedure (i.e., before handling sterile or clean supplies including medications)
- After body fluid exposure
- After contact with wounds
- When moving from a contaminated body site to a clean body site during patient care
- Prior to performing an aseptic task (i.e., placing an IV, preparing an injection)
- After removing a dirty dressing and before applying a new dressing
- After handling equipment, supplies, or linen contaminated with bodily fluids
- After removing other personal protective equipment including gloves
- After touching a patient or patient surroundings, including upon exiting the patient care area.
- Before preparing food
- After using the restroom
- After touching your face, nose or hair or personal device (e.g., pager, phone)

D. Additional Measures: One hand hygiene episode may satisfy multiple hand hygiene indicators. In addition to hand hygiene at the points of entry or exit from the patient care environment, additional hand hygiene may be required after a contaminating event within the patient care area, i.e., "after body fluid exposure". Other unique hand hygiene situations as approved by NACA (Appendix 1).

E. Products for Cleaning Hands:

Type:	**Product:**	**Method:**	**Purpose:**
Hand Decontamination	Alcohol gel	Rub product over all surfaces of hands until dry, at least 20 seconds. Hands must not have visible soiling.	To destroy transient and resident microorganisms on hands without visible soiling.
Antimicrobial Antisepsis	Antimicrobial soap	Rub soap over all surfaces of the hands and wrists, then rinse with water and pat dry with paper towels Total time 1 to 1 ½ minutes.	To remove soil and remove or destroy transient microorganisms.

F. Cleaning Hands with Alcohol Gel:

- Do not for visibly soiled hands
- Apply product to palm of one hand
- Rub hands together, covering all surfaces of hands and fingers until hands are dry
- Follow the manufacturer's recommendations for product volume
- Total time to complete procedure = approximately 20 seconds

G. Cleaning Hands with Soap and Water:

- Stand near the sink, but avoid touching it, as the sink itself may be a source of contamination
- If using a lever-operated paper towel dispenser, dispense a portion of towel before washing hands
- Using tepid water, wet hands. Avoid splashing and keep moisture away from sleeves and clothing. Avoid using hot water, as repeated exposure to hot water may increase the risk of dermatitis
- Apply soap product according to manufacturer's recommendations
- Rub hands together for at least 20 seconds, covering all surfaces of the hands and fingers
- Rinse hands thoroughly
- Dry hands with disposable towel
- Use towel to turn off faucet for handle-operated faucets to prevent contaminating your hands
- Total time shall be 1 to 1 and ½ minutes

H. <u>Hand Lotion</u> – Hand Lotion may be used to prevent skin dryness and damage. There are limitations including:
- Lotion may promote the growth of bacteria. Do not refill containers
- Petroleum-based (ingredients include mineral oil, petrolatum) lotions degrade latex
- Petroleum-based lotions negate the persistent antimicrobial effect of chlorhexidine gluconate (CHG)
- Skin Integrity Guidance can be found in APPENDIX II

I. <u>Responsibilities</u> – The Infection Control Officer (ICO) is responsible for evaluating all NACA facilities to determine the specific locations for dispensers of hand hygiene products to ensure convenience and fire safety. The custodial team is responsible for refilling hand hygiene product dispensers. Additional responsibilities of the ICO include:
- Review product information related to capacity to achieve desired hand hygiene results.
- Review manufacturer information regarding known interactions among such items as hand hygiene products, skin care products, gloves, persistent effects of antimicrobial soaps, and low irritancy potential.
- Review cost value.
- Encourage employee feedback regarding feel, fragrance, and skin tolerance of any products under consideration.
- Evaluation of dispenser functioning and maintenance, suitability to deliver appropriate volume of product, and compliance with regulations and codes.

J. <u>Observations</u> – The ICO and designated staff shall complete a minimum of fifteen quarterly observations of employee compliance within the Family Health Center with hand hygiene requirements utilizing the Hand Hygiene Compliance Log (APPENDIX III). The results shall be presented to the Quality Improvement Committee for review.

K. <u>References</u>:
- NACA will consult reliable resources for use in infection control policies, procedures, and program including but not limited to:
    4. Center for Disease Control (CDC)
    5. World Health Organization (WHO)

6. Association for Professionals in Infection Control and Epidemiology (APIC)

<table>
<tr><td>POLICY: IC 210</td><td>( ) Revision
(X) New</td><td rowspan="2">Original Issue Date: 10/01/24
Revised Date:
Approved by: Board of Directors
Approval Date: 10/16/24; 05/21/25; 5/20/26
Effective Date: 10/17/24; 05/22/25; 5/21/26
Annual Review Date: 05/1/26</td></tr>
<tr><td>Employee Vaccination Policy</td><td>Author: QI & Compliance Director</td></tr>
</table>

I. **POLICY:** The policy of NACA is to prepare NACA staff to provide direct patient care safely while maintaining their own well-being through vaccination.

II. **PURPOSE:** To promote employee health by prevention of communicable disease protection through vaccination efforts.

III. **PROCEDURE:**

A. <u>General Vaccination Guidelines</u> – Vaccines offered at no cost to employees include:
- Diphtheria
- Tetanus
- Pertussis
- Measles
- Rubella
- Hepatitis B
- Influenza
- Varicella
- COVID-19

B. <u>Guidelines for Employees</u> – Newly hired employees are required meet with the Employee Health Coordinator to determine vaccination needs according to Center for Disease Control Immunization Schedule.

POLICY: IC 230	( ) Revision (X) New	Original Issue Date: 10/01/24 Revised Date: Approved by: Board of Directors Approval Date: 10/16/24; 05/21/25; 5/20/26 Effective Date: 10/17/24; 05/22/25; 5/21/26 Annual Review Date: 05/1/26
Food and Drink in Patient Care Areas	Author: QI & Compliance Director	

I. **POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to maintain a safe and hygienic environment for patients, staff, and visitors by restricting the consumption of food and drinks in open containers within all patient care areas of the healthcare setting.

II. **PURPOSE:** The purpose of this policy is to: Protect patient health and safety by minimizing the risk of contamination and infection, prevent attracting pests, and ensure compliance with infection control standards set forth by the Centers for Disease Control and Prevention (CDC) and the Arizona Department of Health Services in designated patient care areas including but not limited to: front desk, exam rooms, laboratory, nursing station.

III. **PROCEDURE:** The presence of staff eating in patient care areas can have various negative effects on ill patients, impacting their physical comfort, psychological well-being, and overall care experience. It is essential for healthcare facilities to enforce policies that minimize these issues, prioritizing patient safety and comfort while ensuring that staff have designated areas for meals.

A. Prohibition of Open Containers:
- No food or beverages in open containers shall be allowed in patient care areas.
- Employees, visitors, and patients may consume open food and drinks only in designated areas such as staff lounges, private offices, unoccupied classrooms and unoccupied conference rooms.
- Areas prohibited from consuming food and drink include but are not limited to the front desk, patient exam rooms, the laboratory, health promotion cubicles, Wellness Center gym area, and the nursing station.
- Closed drinks with lids are acceptable to maintain hydration during scheduled shifts.

B. Pest Control:
- Consumption of food and drinks in patient care areas can attract pests such as rodents and insects. Signs of pests should be immediately reported to the direct supervisor of the area.
- To mitigate the risk, strict adherence to this policy is mandatory, and any food waste must be disposed of promptly in kitchen or staff lounge areas only.

C. Infection Control:
- The CDC emphasizes the importance of maintaining a clean and sanitary environment to prevent healthcare-associated infections (HAIs). Food and drink can introduce pathogens into patient care areas.
- According to the Arizona Department of Health Services, maintaining strict infection control practices is essential in healthcare settings to protect vulnerable populations.

D. Exceptions:

- Exceptions may be made for patients who require food or drink for medical reasons, if this is coordinated with nursing staff to ensure safety and hygiene.

E. Other Considerations:
- Odors and Nausea: Strong food odors from staff meals can trigger nausea or discomfort in patients, particularly those undergoing treatments like chemotherapy or those with sensitive stomachs. Unpleasant smells may exacerbate feelings of illness.
- Cultural Sensitivities: Eating certain foods in the presence of patients may inadvertently offend or discomfort individuals from different cultural backgrounds who have specific dietary restrictions or views regarding food consumption.
- Psychological Impact on Patients: Seeing staff eat can remind patients of their inability to enjoy food due to illness, potentially leading to feelings of isolation, sadness, or frustration. This can affect their mental well-being and overall recovery experience.
- Distraction from Patient Care: Staff members eating in patient care areas may lead to distractions, impacting their focus on patient needs and care. This can result in decreased attention to customer service and care tasks.
- Allergen Exposure: Staff meals may contain allergens that could inadvertently expose sensitive patients which increases the risk of allergic reaction.
- Poor Role Modeling: Staff eating in front of patients may set a poor example regarding dietary choices, especially if unhealthy foods are consumed. This could influence patients' perceptions and behaviors regarding their own nutrition.
- Increased Waste and Risk: Eating in patient care areas can lead to food waste and spills, creating additional cleaning requirements and potentially attracting pests. Maintaining cleanliness becomes more challenging. Electronic equipment is at increased risk for damages caused by spills.
- Impact on Staff Interactions: Eating in front of patients can create a divide between staff and patients, potentially hindering rapport and trust-building, which are essential components of effective patient care.

F. References:

- Centers for Disease Control and Prevention (CDC). Infection Control Guidelines.
- Arizona Department of Health Services. Infection Control Standards.

<table>
<tr><td>POLICY: IC 300</td><td>(X) Revision
( ) New</td><td rowspan="2">Original Issue Date: 02/15/05
Revised Date: 09/20/21; 05/07/24
Approved by: Board of Directors
Approval Date: 10/16/21; 05/15/24; 05/21/25; 5/20/26
Effective Date: 10/17/21; 05/16/24; 05/22/25; 5/21/26
Annual Review Date: 05/1/26</td></tr>
<tr><td>Handling/Disposal of Biohazard Waste</td><td>Author: QI & Compliance Director</td></tr>
</table>

I. **POLICY:** The policy of NACA is to prepare NACA staff to provide direct patient care safely while maintaining their own well-being through vaccination.

II. **PURPOSE:** To promote employee health by prevention of communicable disease protection through vaccination efforts.

III. **DEFINITIONS:**

Biohazardous Waste: Items freely dripping liquid or semi-liquid blood, or potentially infectious materials, or could readily release infectious materials if compressed; items which are coated with dried blood or other potentially infectious materials can release these materials during handling; contaminated sharps; pathological and microbiological waste containing blood or other bodily fluids.

Bodily Fluids: Blood, semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva, or any other bodily fluid visibly contaminated with blood.

IV. **PROCEDURE:**

A. All contaminated sharps and intact syringes (not recapped or bent) are to be placed in the sharp's container at the location where they are used. The containers shall be tightly locked and replaced when the contents reach the fill line.

B. Empty vaccine vials are to be placed the sharps container at the location where it is drawn up.

C. All wastes will be separated into contaminated and non-contaminated types.

D. Non-contaminated waste is placed in regular trashcans. If in doubt, place the item in the red container.

E. Contaminated wastes, including grossly contaminated gloves, are to be placed in the biohazardous containers located in each treatment area. Do NOT carry these items back to the central sterilization area. Dispose of them where they are used. These containers must be closable, leak proof and properly labeled. Don use of appropriate PPE per universal precautions to discard biohazardous waste including gloves, gown, face shield/goggles.

F. Contaminated waste and filled sharps containers may NOT be placed in with the regular trash. They must be placed in the biohazardous waste barrel secured in the Health Promotion Department.

G. For biological spills, wear gloves and clean promptly with a disinfectant. Discard gloves and soiled items in a red plastic biohazard bag disposed of in the biohazardous waste barrel.

H. The biohazardous waste barrel is emptied as contracted with a waste disposal agency.

POLICY: IC 310	( ) Revision (X) New	Original Issue Date: 07/31/23 Revised Date: Approved by: Board of Directors Approval Date: 05/15/24; 05/21/25; 5/20/26 Effective Date: 05/16/24; 05/22/25; 5/21/26Annual Review Date: 05/1/26
Housekeeping and Custodial Services Policy	Author: QI & Compliance Director	

I. POLICY: The policy of NACA is to perform effective and efficient cleaning methods and schedules necessary to maintain a clean and healthy environment in healthcare settings. Accumulation of dust, soil, and microbial contaminants on environmental surfaces is both aesthetically displeasing and a potential source of infection. Routine cleaning is necessary to maintain a standard of cleanliness.

II. PURPOSE: To provide healthcare workers, NACA staff, patients, and visitors with a clean and healthy environment.

III. PROCEDURE: Cleaning shall begin with the least soiled area and move to the most soiled area. Cleaning shall be performed from high to low surfaces.

A. General Cleaning Guidelines:
- All surfaces and fixtures above shoulder height shall be dusted with an approved duster. Duster shall never be shaken. Work shall consistently clockwise or counterclockwise to avoid missing spots.
- Walls, windows, and doors including door handles shall be spot cleaned as needed and cleaned completely on regular schedules.
- Horizontal surfaces including tables, beds, chairs, ledges, lights, and wall fixtures shall be wiped with a clean cloth and approved cleaner.
- Bathrooms shall be cleaned daily. Special attention must be given to the toilet and fixtures. Ceramic tile grout around the commode, tub, or shower shall be free of mold.
- Housekeeping is responsible for supplying the appropriate handwashing agents at sinks.
- Waste shall be collected from all areas at least daily. Many areas may require more frequent collections. Waste containers in bathrooms shall have lids and the lids shall be wiped clean daily.
- Floors shall be cleaned with an EPA-registered disinfectant-detergent solution. Carpeted areas shall be vacuumed regularly.
- Staff refrigerators, freezers, and ice makers shall be cleaned weekly and as needed.
- Expired, spoiled, or unlabeled items (employee name and date) shall be discarded.
- Cleaning equipment shall be clean, well-maintained, and in good repair or to be replaced. The cleaning items such as disinfectant, water, bucket, cleaning cloths, and mop heads shall be changed routinely and after they are used to clean blood or contaminated areas.

B. Personal Protective Equipment (PPE):
- Gloves shall be worn when performing any cleaning activities. Heavy-duty work gloves are recommended. When the gloves are removed the employee must wash their hands.
- When there is a potential for splashing or splattering, a fluid-resistant gown or apron, protective

eyewear, and a mask shall also be worn.
- Disposable apparel shall be discarded into the appropriate waste containers after use.

- When cleaning a patient's room that has suspected or confirmed tuberculosis, the appropriate respiratory protection shall be worn.
- NACA shall provide all necessary personal protective equipment for housekeeping & custodians to perform their essential job functions.

C. Cleaning Schedule Exam Rooms:
- After each patient, all horizontal surfaces such as bed, tables, and chairs shall be cleaned with disinfectant, and wall and floors shall be spot cleaned as needed.
- At least daily: floors shall be mopped, vacuumed, and waste cans shall be emptied.

D. Cleaning Schedule – All Other Areas:
- In entrances, lobbies, waiting areas and halls, clean floors and upward facing surfaces are cleaned daily and as needed.
- Entry areas are swept to pick up sand, dust, and debris weekly.

E. Trash Pickup and Disposal:
- Biohazardous/Infectious waste will be red bagged with the biohazard label in impervious containers. They will be placed in accordance with applicable regulation for off-site pick-up and disposal.
- Other waste will be promptly delivered to an approved trash disposal dumpster.
- Trash will be collected at least daily and as needed.

F. Isolation Room Cleaning (Airborne, Droplet, and Contact)
- Before entering room, don appropriate personal protective equipment.
- All horizontal surfaces of furnishings, exam table and frame shall be cleaned used a germicidal wipe.
- Floor shall be mopped using a healthcare grade cleaner.
- Trash shall be emptied, and a new liner placed in the waste can.
- Remove gloves and discard. Wash hands and use paper towel to turn off water.
- Remove mask, discard in trash to be discarded.
- With paper towel, open door.   Leave room, taking trash upon exit.
- Wash hands thoroughly.

G. Terminal Cleaning
- Use same procedure with gown, mask, and gloves as with general cleaning.
- Discard disposable items into waste can. Place trash liner by door.
- Wash furniture and all horizontal surfaces in the room including the door handles and telephone, keyboard, mouse.
- Thoroughly wash spotting on the walls.
- Remove gloves, gown, and mask in the same way as when doing general cleaning.
- Bag all materials.
- Wet mop floor, then discard mop head.
- Leave room, taking trash upon exit.
- Wash hands thoroughly.

NACA
NATIVE AMERICANS FOR COMMUNITY ACTION

<table>
<tr><td>POLICY: IC 320</td><td>( ) Revision
(X) New</td><td rowspan="2">Original Issue Date: 04/25/24
Revised Date:
Approved by: Board of Directors
Approval Date: 05/15/24; 05/21/25; 5/20/26
Effective Date: 05/16/24; 05/22/25; 5/21/26
Annual Review Date: 05/1/26</td></tr>
<tr><td>Cleaning and Disinfecting Patient Care Equipment</td><td>Author: QI & Compliance Director</td></tr>
</table>

I. **POLICY:** Non-critical patient care equipment (that touch intact skin) shall receive low level disinfection with a hospital grade disinfectant before use on each patient. Surfaces shall be precleaned when visibly soiled before being disinfected. Low Level disinfection is performed following the manufacturer's instructions for use (IFU) using germicidal wipes.

II. **PURPOSE:** To minimize the risk of transmitting infections, between patients and employees, via contact with equipment that may be contaminated.

III. **PROCEDURE:**

A. The following grid outlines the procedure to be utilized for cleaning some of the most used patient care equipment:

Equipment	User	Training
Vital Machine	Nursing	Before use on each patient
BP Cuff/Machine	Nursing	Before use on each patient
Glucose Monitor	Nursing	Before use on each patient
Tray Tables	Nursing/Provider	Daily & after each discharge
Thermometer	Nursing	Before use on each patient
Walkers	Nursing	Before use on each patient
Wheelchairs	Nursing	Before use on each patient
EKG/Spirometry Machine	Nursing/Provider	Before use on each patient
Oto/Ophthalmoscope	Nursing/Provider	Before use on each patient
Med Refrigerator/ Freezer	Nursing	Weekly

B. <u>Discharge Room Cleaning</u> – All reusable patient care equipment in the room when the patient is discharged shall be cleaned using a hospital grade disinfectant. Items to be cleaned include but are not limited to exam table, tray table, chairs, doorknob, light switch, counter, and cabinet handles.

POLICY: IC 330	( ) Revision (X) New	Original Issue Date: 07/31/23 Revised Date: Approved by: Board of Directors Approval Date: 05/15/24; 05/21/25; 5/20/26 Effective Date: 05/16/24; 05/22/25; 5/21/26 Annual Review Date: 05/1/26
Infection Control for Cleaning & Intermediate-Level Disinfection	Author: QI & Compliance Director	

I. **POLICY:** It is the policy of NACA to establish guidance to NACA personnel for achieving safe and effective cleaning & intermediate-level disinfection of reusable medical devices. The policy excludes high-level and sterilization processes. The expected outcome is that patients are free from signs and symptoms of infection.

II. **PURPOSE:** The purpose of this policy is to establish infection control safety measures to be implemented by NACA to ensure the safety of staff, patients, and visitors prior to, during and post cleaning and/or intermediate-level disinfection procedures.

III. **DEFINITIONS:**

Cleaning: The removal of adherent visible soil (e.g., blood, protein substances, and other debris) from medical devices by a manual or mechanical process, as part of a decontamination process.

Disinfection: A process that destroys pathogens and other microorganisms by physical or chemical means. Disinfection processes do not ensure the same margin of safety associated with sterilization processes. The lethality of the disinfectant leads to subcategories.

High Level Disinfection: A lethal process utilizing sterilant under less than sterilizing conditions. This process kills all forms of microbial life except for large numbers of bacterial spores.

Sterilization: The absolute state where all forms of life have been eliminated. In a particular sense absolute sterility cannot be proven, therefore, sterility is considered achieved when organisms are eliminated, inactivated, or destroyed such that they are undetectable in standard media in which they have previously been found proliferate.

IV. **PROCEDURE:**

A. Classify medical device usage to determine FDA requirement for disinfection/sterilization as per the table below:

Usage	Intermediate Disinfection	High Level Disinfection/Sterilization

Intact skin with minimal likelihood of transmissible bacteria, organisms, etc.	X	
Broken skin and/or mucosal membrane		X

B. Follow manufacturer's written instructions for use when preparing and using disinfectants.

C. Check for expiration dates.

D. Do the following PPE during cleaning, disinfecting, transport, and chemical handling.

E. Protective eye wear (e.g., goggles, face shields)
- Mask (e.g., surgical or N95)
- Disposable protective gloves
- Protective gown

F. Thoroughly clean all surfaces of the medical device prior to disinfection according to manufacturer's written instructions as per acceptable products.

G. Follow manufacturer's written instructions for use of intermediate disinfectant(s) as per acceptable products table in a well-ventilated area. Make note of wet contact time.

H. Upon completion of disinfection, all surfaces of medical device shall be wiped with an alcohol prep pad and allowed to air dry completely.

I. Discard cleaning and disinfectant agents according to local regulation for infectious waste disposal.

J. Discard PPE according to local regulation for infectious waste disposal.

K. Medical Device is ready for use.

POLICY: IC 340	(X) Revision ( ) New	Original Issue Date: 12/21/22 Revised Date: 01/05/23 Approved by: Board of Directors Approval Date: 01/18/23; 05/15/24; 05/21/25; 5/21/26 Effective Date: 01/19/23; 05/16/24; 05/22/25; 5/21/26 Annual Review Date: 05/1/26
Infection Control for Construction and Maintenance	Author: QI & Compliance Director	

I. **POLICY:** It is the policy of NACA to establish and monitor infection control and risk during construction and maintenance.

II. **PURPOSE:** The purpose of this policy is to establish interim infection control safety measures to be implemented by NACA to ensure the safety of staff, patients, and visitors is not compromised.

III. **DEFINITIONS:**

HVAC: Heating, Ventilation, Air Conditioning

IICSM: Interim Infection Control Safety Measures

CDC: Center for Disease Control and Prevention

HICPAC: Healthcare Infection Control Practices Advisory Committee

AIA: American Institute of Architects

AORN: Association of Perioperative Registered Nurses

APIC: Association for Professionals in Infection Control and Epidemiology

IV. **PROCEDURE:**

A. The Quality Director will classify the project based on the Construction Matrix.

B. If the classification is a Class 1 project, the Quality Director will provide Infection Control a description of the work and area(s) affected.

C. If the classification is a Class II-IV project, the Quality Director will provide Infection Control with a written copy of the scope of work of the project, estimated timeline of the project, and description of planned barriers and air/scrubber and/or negative air machine(s).

D. Based on the scope of work and site of the construction/maintenance, Infection Control will assess the project to validate the classification of the project.

E. If the work is Class II-IV, Infection Control will provide the Quality Director with a copy of the Pre-Construction Checklist and Daily IICSM checklist.

F. If necessary, following Infection Control's classification of the project, the Quality Director will provide Infection Control with the following information prior to its implementation:
   - Updated Description of Barriers and air scrubber and/or negative air machine(s).

G. If, at any time during the project, the scope of work changes, the Executive Team Sponsor and Quality Director will provide Infection Control with the following information prior to its implementation:
   - Updated scope of the work for the project.
   - Estimates of any changes in the timeline.
   - Updated description of barriers, etc.
   - If construction occurred in an area where patients will be present and provided care, final particle counts must be obtained once the terminal is clean before the area can be cleared for the department to use.

CONSTRUCTION CLASS MATRIX:

Level of Risk	Type A	Type B	Type C	Type D
Group 1	I	II	II	III/IV
Group 2	I	II	III	IV
Group 3	I	III	II/IV	IV
Group 4	II	III/IV	III/IV	IV

TYPE OF CONSTRUCTION:

Type A	Inspection and Non-Invasive Activities: • Painting (not sanding) • Addition of Wall Coverings • Visual Inspection above ceiling tiles
Type B	Small-scale, short duration (within 1 business day) activities which create minimal dust: • Installation of telephone/data cables • Minimal cutting of walls where dust can be controlled
Type C	Activities where moderate-high levels of dust is created: • Sanding of walls • Major cabling activity • New wall construction • Projects that cannot be completed within 1 business day • Demo/Removal of fixed building components • Removal of floor coverings/multiple ceiling tiles • Moderate Plumbing
Type D	Major Demolition and Construction: • New Construction • Demolition of walls and floors • Removal of complete cabling system

	• Major Plumbing

LEVELS OF RISK:

Group 1 (low)	• Office Areas • Non-Patient Care Areas
Group 2 (medium)	• Patient care areas not specified in group 3 or 4 • Staff Lounge Kitchen
Group 3 (medium/high)	• Medication Room(s)
Group 4 (high)	• Sterile Supply Storage • Instrument Disinfection Area

NACA
NATIVE AMERICANS FOR COMMUNITY ACTION

POLICY: IC 400	( ) Revision (X) New	Original Issue Date: 07/31/23 Revised Date: Approved by: Board of Directors Approval Date: 05/15/24; 05/21/25; 5/21/26 Effective Date: 05/16/24; 05/22/25; 5/21/26 Annual Review Date: 05/1/26
Food and Nutrition Services	Author: QI & Compliance Director	

I. **POLICY:** It is the policy that NACA is responsible for the distribution of food which has been purchased, stored, prepared, and served in a safe, sanitary manner and for maintaining and cleaning work areas, storage areas, and equipment for handling of supplies in accordance with state and local health department standards.

II. **PURPOSE:** To reduce the risk of foodborne pathogen transmitted infections by providing guidelines for safe food handling, preparation, storage, and disposal.

III. **PROCEDURES:**

A. Temperature Guidelines:

Food	Temperature
Cold Food	At or below 40 degrees
Hot Food	At or above 140 degrees
Frozen Food	At or below 0 degrees

B. Purchasing and Receiving Food:
- Purchased food must be inspected and approved before serving.
- Select products in commercially filled, unopened packages when possible.
- Reject containers that appear contamination may have occurred.

C. Storage of Food:
- Store food only in designated areas.
- All goods should be stored in clean wrappers or containers with covers and properly marked (i.e., date item received and contents).
- Keep storage areas (and vehicles used to transport food) clean.
- Store food at least 6 inches above floor level and away from walls to facilitate cleaning and reduce pest risk.
- Rotate stock; use goods in the order in which they were received.
- Check all goods on a periodic basis for expiration dates.
- Food should be stored at appropriate temperatures.

D. Food Preparation:
- Wash hands and clean nails before contact with food, after using the toilet, and after contact with unclean equipment and work surfaces, soiled clothing, etc.

E. Handling Raw Food:

- Wear a hairnet or cap
- Avoid touching food directly. Use appropriate utensils or gloves to minimize touch contamination.
- Meet state and local regulations for food handlers.
- Use commercially filled unopened packages whenever possible (e.g., pasteurized milk, homogenized powdered eggs).
- Select appropriate equipment that is easy to clean, smooth and free from cracks, crevices, and pits. Use materials resistant to cracking and chips, preferably plastics, hard rubber, and nonabsorbent wood.
- Separate cutting boards are used for meat, poultry, fish, raw fruits and vegetables, and cooked foods.
- All working surfaces, utensils and equipment should be cleaned thoroughly after each use.
- Workers should be trained to operate and maintain equipment correctly.
- Traffic of unauthorized individuals through food preparation and services areas should be limited.

F. Holding and Serving Prepared Food:
- Avoid thawing and refreezing food products.
- Avoid precook and holding means for final cooking.
- Reduce opportunities for introduction of microorganisms.
- Establish safe times for food storage.

G. Management of Waste:
- Use leak-proof, easily cleaned, pest proof garbage containers with tight-fitting lids.
- Place garbage into containers promptly.
- Wash containers in an area provided with a floor drain connected to a sanitary sewer system.
- Use appropriate control measures to prevent access and to exterminate pests.

H. Insect and Rodent Control:
- Routine exterminating is in effect.
- Space under equipment is maintained free of organic residue.
- All kitchen waste is removed when full.

POLICY: IC 410	(X) Revision ( ) New	Original Issue Date: 06/04/24 Revised Date: 5/14/26 Approved by: Board of Directors Approval Date: 07/17/24; 05/21/25; 5/20/26 Effective Date: 07/18/24; 05/22/25; 5/21/26 Annual Review Date: 05/1/26
Service Animal Accommodation for Patients	Author: QI & Compliance Director	

I. POLICY: Native Americans for Community Action (NACA) is committed to providing equal access to healthcare services for all individuals, including those with disabilities who use service animals. NACA recognizes the important role that service animals play in assisting individuals with disabilities and acknowledge the rights of patients to be accompanied by their service animals while receiving care at NACA facilities.

II. PURPOSE: The purpose of this policy is to ensure that individuals with disabilities have the right to be accompanied by their service animals when accessing services at NACA. This policy aims to promote inclusivity, accessibility, and compliance with relevant laws and regulations, including the Americans with Disabilities Act (ADA).

III. DEFINITIONS:

Term	Definition
Service Animal	Dog(s) that are individually trained to work or perform tasks for the benefit of an individual with disabilities. Animals whose function is to provide comfort or emotional support, therapy dogs, or companion dogs do not qualify as service animals under the ADA.

IV. PROCEDURES:

A. Service Animals:
- Dogs
- Any breed and any size of dog
- Trained to perform a task directly related to a person's disability

B. Non-Discrimination:
- NACA shall not discriminate against individuals with disabilities who use service animals. Patients with disabilities are allowed to be accompanied by their service animals in all areas of the clinic where patients are normally allowed to go.

C. Verification:
- Staff may only ask patients for certain information using two questions:
    1. Is the service animal required because of a disability?
    2. What work or task has the dog been trained to perform?
- Proof or documentation of certification for the service animal is not required.

D. Control and Behavior:

- Patients are responsible for the control and behavior of their service animals at all times. If the service animal is out of control and the patient does not take effective action to control it, clinic staff may ask that the animal be removed.

E. Health and Safety:
- NACA reserves the right to exclude a service animal from its premises if the animal poses a direct threat to the health or safety of others. Reasonable modifications to policies will be made to allow the individual with a disability to access healthcare services without the service animal present if feasible.

F. Allergies:
- The clinic will provide reasonable accommodation in cases where patients or staff have allergies to animals. This may involve assigning the patient to a different area of the clinic or taking other steps to minimize exposure.

G. Environmental Cleaning:
- Areas occupied by service animals shall be cleaned and disinfected after the visit as appropriate.

Laboratory Services (LS) Policies

Annual Review Change Summary — May 2026

Reviewed by: Francisco Rendon, QI & Compliance Director

Annual Review Date: May 20, 2026 | Effective Date: May 21, 2026

Overview

The following Laboratory Services (LS) policies were reviewed as part of the May 2026 annual policy review cycle. Two policies received substantive revisions requiring Board of Directors approval. LS 200 was reviewed and required no substantive changes.

Policies Requiring Revision

LS 210 — Specimen and Biological Product Handling Policy

Change:

Added a requirement that personnel handling specimens adhere to Standard Precautions and follow exposure control procedures in accordance with CDC infection prevention guidance.

Rationale:

Standard Precautions are the foundational tier of infection prevention in healthcare settings, required by OSHA's Bloodborne Pathogens Standard (29 CFR 1910.1030) and reinforced by CDC guidance. AAAHC infection control standards require that specimen handling procedures align with nationally recognized infection prevention practices. The prior policy addressed labeling, transport, and storage but did not explicitly require adherence to Standard Precautions during the handling process itself. Adding this language closes a gap identified during the 2026 review, ensures that specimen handling procedures are consistent with the IC policies in force at NACA, and creates a clear, auditable standard for staff training and compliance monitoring.

LS 220 — Emergency Laboratory Testing

Change:

Replaced vague language about flagging critical results with a specific, time-bound requirement: critical or life-threatening test results shall be communicated to the ordering provider immediately, and no later than 60 minutes from result availability.

Rationale:

The prior language -- "flagged for immediate attention and communicated directly to the responsible healthcare provider" -- lacked a defined timeframe, creating ambiguity in accountability and making compliance difficult to audit. AAAHC standards for clinical laboratory services require that policies for reporting critical values include defined notification timeframes. The 60-minute benchmark is consistent with common practice among FQHCs and ambulatory care settings and reflects nationally recognized critical value reporting standards. A specific, measurable standard supports staff accountability, enables QI monitoring of compliance rates, and reduces the risk of communication delays that could compromise patient safety in time-sensitive clinical situations.

Policies Reviewed — No Substantive Changes

Policy	Policy Name
LS 200	Laboratory Quality Control Equipment Testing

LS 200 (Laboratory Quality Control Equipment Testing) was reviewed and required no substantive changes. Dates, approval, and effective dates have been updated to reflect the May 2026 annual review cycle.

List of Laboratory Services (LS) Policies:

LS 200 Laboratory Quality Control Equipment Testing
LS 210 Specimen and Biological Product Handling Policy
LS 220 Emergency Laboratory Testing

POLICY: LS 200	(X) Revision ( ) New	Original Issue Date: 03/08/05 Revised Date: 07/05/22; 05/03/24 Approved by: Board of Directors Approval Date: 07/20/22; 05/15/24; 05/21/25 Effective Date: 07/21/22; 05/16/24; 05/22/25 Annual Review Date: 05/21/25
Laboratory Quality Control Equipment Testing	Author: Medical Staff Committee	

I. **POLICY:** Native Americans for Community Action (NACA) is committed to upholding the highest standards of accuracy, reliability, and quality in our laboratory testing services. The policy of NACA is to ensure the integrity of our test results and the safety of our patients.

II. **PURPOSE:** To provide guidelines for conducting regular quality control equipment testing. This policy and procedure outline the specific procedures for performing quality control testing on each specified test, including testing frequency, acceptance criteria, documentation requirements, and corrective actions in case of deviations. All laboratory personnel are expected to follow these procedures diligently and to document their testing results accurately.

III. **PROCEDURE:**

A. Responsibilities: The Clinical RN shall be responsible for the oversight of the Family Health Clinic's Laboratory Quality Control including testing, designation of testing, educating clinical staff, and ensuring compliance with manufacturer instructions, local, state, and federal laws and regulations, and accreditation regulations for all laboratory equipment. The Clinical RN shall ensure that appropriate reporting and documentation requirements are met.
- Clinical staff are responsible for conducting testing in compliance with manufacturer instructions, local, state, and federal laws and regulations, and accreditation regulations.

B. Quality control testing shall be completed for the following laboratory tests:
- Cholesterol, urinalysis
- hCG (pregnancy)
- Influenza A & B
- HgbA1c
- Blood Glucose
- Covid/Flu/RSV
- Strep A
- Rapid HIV
- OC Light Fit S
- PT/INR testing

C. Cholesterol Testing: Quality control tests shall be completed and documented monthly, with each new shipment, with each new lot number according to manufacturer's recommendations.

D. Urinalysis and hCG Testing: Quality control testing for urinalysis and hCG testing shall be completed and documented upon opening a new test kit.

E. <u>Influenza A & B Testing:</u> Positive and negative control testing shall be completed and documented with each new shipment and with each new lot number according to manufacturer's recommendations.
   - Internal Controls: Influenza A & B Test device has built-in controls. Staff shall follow manufacturer instructions accordingly.
   - External Controls: External control testing shall be completed with each new operator, with each shipment, with each new lot and as per local, state, federal, and accreditation requirements. Staff shall follow manufacturer instructions accordingly.

F. <u>HgbA1c Testing:</u> Quality control testing shall be completed and documented monthly, with each new shipment, with each new lot, and as needed.

G. <u>ACCU-CHEK Whole Blood Glucose:</u> High and Low controls shall be completed and documented daily when the Family Health Center is open, anytime when a patient's glucose result is in question, after a monitor has been dropped or damaged, when a new lot of controls is opened, when the test strips have been exposed to temperatures outside acceptable storage conditions, and/or whenever the operator wants to check the performance of the monitor and test strip.

H. <u>SARS-COV/2FLU/RSV/STREP A:</u> Positive and negative controls shall be completed and documented monthly, with each new shipment, with each new lot even if it is the same lot previously received, with each new operator, and when problems (storage, operator, instrument, or other) are suspected or identified.

I. <u>Strep A Testing:</u> Quality control tests shall be completed and documented once per kit and as deemed necessary.
   - Internal Quality Control: Internal procedural controls are included in the test and shall be followed as per manufacturer's instructions.
   - External Quality Control: Positive and negative external controls shall be completed and documented once per kit, and as deemed necessary. External positive and negative controls are supplied in the kit. Alternatively, other Group A and non-Group A Streptococcus ATCC reference strains may be used as external controls. Some commercial controls may contain interfering preservatives: therefore, other commercial controls are not recommended.

J. <u>HIV Testing:</u> Quality Control Tests shall be completed and documented once per kit, with each new shipment, and as deemed necessary.

K. <u>OC-Light Fit S (Fecal Immunochemical Test):</u> Quality Control Tests shall be completed and documented once per kit and as deemed necessary.
   - Internal Quality Control: the internal quality control is located in the Procedural Control Region of the test strip. This control assures the operator that (A) sample addition and migration through the test strip has occurred and that (B) the control anti-mouse antibody and the reporter MAb are intact and functional. This control does not ensure that the capture antibody is accurately detecting the presence or absence of Hb in the sample.
   - External Quality Control: external controls are used to assure the operator that the captured and conjugated antibodies are present and reactive. External controls will not detect an error

in performing the patient test procedure. Controls should be assayed once per kit. If controls do not perform as expected, the test results shall not be used. Repeat the test or call the number indicated on the label or instructions.

L. Coaguchek XS System (PT/INR): The Coaguchek XS System has quality control functions integrated into the meter and test strips; it is never necessary to run quality control tests with liquid quality controls. The meter automatically runs its own quality control test as part of every blood test. Staff shall follow instructions on the meter's display and consult manufacturer's instructions for any error message.

M. Storage: All vials, strips and other testing equipment shall be stored according to the manufacturer's instructions including the storage temperature, storage conditions (i.e., away from direct sunlight), and expiration date. The date of opening and the expiration shall be labeled on all vials. Opened vials, when permitted, shall be stored according to manufacturer's recommendations.

N. Deviations: If there is an out of range or unexpected result, the quality control shall be repeated using the designated supplies as per manufacturer's instructions. If the repeat test fails, the equipment shall be tagged out of service, removed from patient care area and a service ticket shall be submitted. If the equipment is unrepairable, it shall be removed from inventory and disposed of per manufacturer's instructions. If testing determines supply (i.e., test strips), the defective items shall be clearly labeled as defective, removed from patient care area, and disposed of per manufacturer's instructions.

O. Documentation and Recordkeeping: All testing shall be documented on logs corresponding to the test and maintained in the clinic. Documentation may include but not be limited to:
- Date
- Operator name, initials, and/or signature
- Kit lot numbers
- Kit expiration dates
- Control lot numbers
- Control expiration dates
- Normal control range
- Abnormal control range
- Results
- Action(s) taken

P. Training and Education: Clinical staff and other personnel completing laboratory testing shall receive initial and ongoing training, as needed, from the Clinic RN regarding the procedures for quality control testing for the applicable laboratory procedures and equipment, prior to completion of any laboratory quality control equipment testing.

NATIVE AMERICANS FOR COMMUNITY ACTION

POLICY: LS 210	( ) Revision (X) New	Original Issue Date: 03/01/24 Revised Date: Approved by: Board of Directors Approval Date: 03/20/24; 05/21/25 Effective Date: 03/21/24; 05/22/25 Annual Review Date: 05/21/25
Specimen and Biological Product Handling Policy	Author: Medical Staff Committee	

I. **POLICY:** It is the policy of NACA to handle, store, and transport specimens and biological products in a manner which contribute to the high standards of safety, efficacy, quality, and integrity.

II. **PURPOSE:** The purpose of this policy is to establish guidelines for the identification, storage, and transportation of specimens and biological products to ensure their integrity, safety, and traceability throughout the handling process.

III. **DEFINITIONS:**

Term	Definitions
Specimens	Any biological material, such as blood, tissue, urine, or other bodily fluids, collected for analysis or diagnostic purposes.
Biological Products	Any substance derived from living organisms that is used for therapeutic or diagnostic purposes, including but not limited to vaccines, blood products, and cell lines.

IV. **PROCEDURE:**

A. Collection and Identification:
- Specimens and biological products must be collected by qualified personnel.
- Personnel handling specimens shall adhere to Standard Precautions and follow exposure control procedures in accordance with CDC infection prevention guidance
- All specimens and biological products containers must be clearly and accurately labeled in the presence of the patient at the time of collection with the following information:
    1. Patient identification (name, date of birth, unique identifier)
    2. Collection date and time
    3. Type of specimen or product
    4. Any relevant clinical information, as applicable

B. Storage and Preservation:
- Specimens and biological products must be stored in accordance with applicable regulations and best practices to maintain their integrity and stability.
- Proper segregation and labeling of stored specimens and products must be enforced to prevent mix-ups and cross-contamination.

C. Transportation:
- Specimens and biological products must be transported in compliance with relevant regulations and guidelines for the safe and secure handling of biological materials.
- Transport containers must be leak-proof, insulated, and designed to maintain appropriate

temperature conditions during transit.

- Transportation performed by Sonora Quest and LabCorp Couriers.

D. Security and Access Control:
- Access to specimen storage areas is restricted to authorized NACA personnel only.
- Security measures are in place to prevent unauthorized access, theft or tampering including a locked patient care area from the public.

E. Disposal:
- Disposal of biological waste and expired specimens adhere to established safety and environmental guidelines.
- Proper disposal methods are used to prevent contamination and to protect the environment.

F. Compliance:
- Compliance with this policy is mandatory for all personnel involved in specimen and biological product handling.
- Non-compliance with this policy may result in disciplinary action.

POLICY: LS 220	( ) Revision (X) New	Original Issue Date: 03/01/24 Revised Date: Approved by: Board of Directors Approval Date: 03/20/24; 05/21/25 Effective Date: 03/21/24; 05/22/25 Annual Review Date: 05/21/25
Emergency Laboratory Testing	Author: Medical Staff Committee	

I. **POLICY:** It is the policy of NACA to facilitate the diagnosis and management of acutely ill patients requiring urgent medical intervention by ensuring expedited analysis of clinical specimens.

II. **PURPOSE:** The purpose of this policy is to establish guidelines for the timely and appropriate utilization of emergency laboratory testing ordered at NACA to support the diagnosis and management of acute medical conditions, facilitate rapid decision-making, and improve patient outcomes.

III. **PROCEDURE:**

A. Prioritization of Testing:
- Emergency laboratory test ordering shall be prioritized based on the acuity of the patient's condition, clinical indication, and potential impact on patient care and outcomes.
- Emergency laboratory tests that cannot be performed at NACA shall be referred to appropriate local laboratory facilities or the emergency room based on the NACA providers' discretion.

B. Test Selection and Ordering:
- Emergency laboratory tests shall be ordered based on clinical indications and in accordance with established protocols for the evaluation of acute medical conditions.
- NACA providers will consider the urgency of the situation, potential impact on patient management, and the availability of test results when determining the necessity of emergency laboratory testing.
- NACA providers are responsible for appropriately ordering and requesting emergency laboratory test(s) based on patient clinical presentation and urgency of the situation. Clear documentation of the reason for the emergency test is required.

C. Test Prioritization:
- Laboratories commit to prioritize emergency tests over routine testing to ensure rapid processing and reporting of results.
- Critical or life-threatening tests will be identified for immediate processing, and results will be communicated expediently to the ordering healthcare provider.

D. Specimen Collection:
- Specimens for emergency laboratory testing will be collected promptly and in accordance with established standards for specimen identification, labeling, and handling to prevent preanalytical errors.
- Healthcare personnel responsible for specimen collection will be appropriately trained and competent in specimen collection techniques.

E. Result Reporting:

- Laboratory results for emergency tests will be reported promptly to the ordering healthcare provider through established communication channels, which may include electronic health records, phone calls, or other secure methods of communication.
- ~~Critical or significantly abnormal results will be flagged for immediate attention and communicated directly to the responsible healthcare provider.~~ Critical or life-threatening test results shall be communicated to the ordering provider immediately, and no later than 60 minutes from result availability.
- Patients shall be notified upon NACA provider review via telephone and/or other patient care consented methods and may be delegated at the discretion of the provider to nursing personnel.

F. Documentation:

- All emergency laboratory testing activities, including test orders, specimen collection, processing, and result reporting, will be accurately documented in the patient's medical record.
- Documentation will include the rationale for ordering emergency tests, relevant clinical information, and actions taken based on the test results.

G. Compliance:

- All emergency laboratory testing activities will comply with applicable regulatory requirements, including those set forth by accrediting bodies, such as the Clinical Laboratory Improvement Amendments (CLIA), and other relevant regulatory agencies.

NATIVE AMERICANS FOR COMMUNITY ACTION INFECTION PREVENTION AND CONTROL PROGRAM 2026

Introduction

Native Americans for Community Action (NACA) Infection Prevention and Control Program (IPC) is designed to ensure the safety of patients, staff, and visitors within its healthcare environment by reducing the risk of acquiring a healthcare associated infection (HAI). The process utilizes published evidence practice guidelines from professional organizations, Accreditation Association For Ambulatory Health Care (AAAHC) standards, Centers for Medicare and Medicaid (CMS) and The Centers for Disease Control and Prevention (CDC). The Infection Control (IC) Program maintains a culture of safety that promotes zero tolerance for the occurrence of preventable HAIs and noncompliance with established infection prevention and control practices. The IPC program is reviewed at least annually by the NACA Quality Improvement Committee and by the NACA Medical Executive Committee to maintain consistency with the new recommendations and standards of the professional organizations.

Structure and Authority

The responsibility for monitoring and evaluating the NACA Infection Prevention and Control program is vested in a multidisciplinary team. The Infection Control Committee is responsible for program oversight and recommends infection prevention and control interventions for staff. The Infection Control Coordinator, in collaboration with the Medical Director, has authority to initiate immediate infection prevention actions when a risk to patient or staff safety is identified, without waiting for committee review. The NACA Quality Improvement and Compliance Director and the Infection Control Coordinator serve as the representatives to provide leadership support for the program. The committee shall meet quarterly to address infection prevention and control issues as gathered by the Medical Director, Infection Control Coordinator, and Director of Operations.

The Infection Control Committee (ICC) consists of a Licensed Independent Practitioner, Infection Control Coordinator, Nursing Staff, Medical Director, Director of Operations and the Quality Improvement and Compliance Director.

The Chief Executive Officer and Board of Directors receive a quarterly report including but not limited to quarterly rounding findings, communicable disease reporting, sharps injuries, and hand hygiene compliance data for review and informational purposes. The committee members' role is to educate supervisors and staff regarding compliance with regulatory agencies to assure infection prevention measures are met.

The Chief Executive Officer has delegated authority to the Medical Director, Director of Operations, Director of Quality and Compliance, Infection Control Coordinator, and the Clinical RN(s) on duty, to take immediate and appropriate action in the event of an emergency where there is a clear and imminent danger that poses a threat to health and/or life.

The committee shall have access to resources needed to develop, manage, and evaluate infection control and prevention activities. Access includes but is not limited to physical access to buildings, facilities, computers, patient charts, electronic records, employee health files as it applies to infection control and prevention activities, educational activities, and infection control and prevention professional activities.

Reporting Structure

NACA Infection Control Committee provides quarterly reports or as required regarding its program and activities to the NACA Quality Improvement Committee, NACA Quality Improvement Committee, and NACA Governing Body. Appropriate reports of surveillance of communicable disease data are sent to the Coconino County Health Department and key stakeholders to share with the staff.

Risk Assessment

A risk assessment is performed to identify key internal and external infection vulnerabilities that can inhibit efforts to control infections throughout the organization as it pertains to Flagstaff, Arizona within Coconino County, and surrounding areas within Northern Arizona and the Navajo/Hopi Reservations. This risk assessment evaluates infection risks specific to NACA and its community establishes infection control priorities, sets goals, and objectives. This assessment is re-evaluated annually and as needed with changing standards or evidence-based practices. NACA will partner with Indian Health Services, Arizona Department of Health Services (ADHS), Coconino County Health Department (CCHD), CDC, and World Health Organization (WHO) for direction of these standards and practices. NACA primarily refers to the "Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care" for the adequate risk assessment at the Family Health Center. Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care (cdc.gov)

NACA's population includes American Indian/Alaskan Natives from many federally recognized tribes, non-indians, insured, uninsured, underinsured, birth to end of life, and considers all social determinants of health. Based on this population, NACA has identified the

following as prioritized risks: Urinary Tract Infections, Respiratory Illness, Gastrointestinal Disease, Parasitic Infection, Skin & Skin Structure Disease, and Blood Borne Disease.

NACA Risk assessment is performed by personnel educated in Infection Prevention.

Program Goals

The primary goal of the NACA Infection Control Program is to reduce the risk of acquiring and transmitting healthcare associated infections among patients, visitors, and staff.

The 2026 NACA Infection Control Program Goals

Goal	Objectives	Measures
1. Provide updated guidelines for recommended healthcare prevention and practice	1.1 Improve Employee Health and Immunization 1.2 Improve healthcare providers' hand hygiene compliance	• Improve % of Flu, Hep A/B & MMR vaccine administered to staff • Improve % of clinical staff fit testing • Standardize the CDC hand hygiene tool • Provide re-education if compliance is below 85% • ~~Monitor HH compliance % quarterly~~
2. Ensure standardization of infection control measure methods	2.1 Develop IPC Risk Assessment 2.2 Ensure NACA meets the requirements of CDC	• Introduce IPC Risk Assessment and approve at QI Committee • Review Policies and Procedures annually • Conduct IPC review annually
3. Enhance the Employee Health Immunization Program	3.1 Promote Awareness 3.2 Increase Participation Rates 3.3 Ensure Compliance with CDC recommended schedule	• Track Employee Vaccination Rate(s) • Monitor CDC Recommended Status for Employees • Gather Employee Feed back and Satisfaction regarding program • Monitor effectiveness of program

Surveillance Plan

A. Eliminate Transmission of Infection
    1. Improve Hand Hygiene Compliance
    2. Quarterly Infection Control Rounds and Report presented to QI Committee and Board of Directors
    3. Data is trended quarterly, trends result in documented corrective actions.
B. Report Communicable Disease to Coconino County Health Department
    1. All reportable communicable diseases are reviewed for evidence of trends
    2. Communicable disease reports are forwarded to Coconino County Health Department
C. Reduce Contaminated Sharps related incidents
    1. Improve Sharp(s) Compliance
    2. All sharps related incidents are reviewed for evidence of trends

Responsibilities of the NACA Infection Control Program

1. Development and revision of annual infection prevention risk assessment(s)
2. Development and contribution to infection control surveillance and performance improvement efforts
3. Improve Employee Health and Immunization
4. Improve Healthcare Providers' Hand Hygiene Compliance
5. Ensure the NACA IPC program meets CDC standards
6. Ensure compliance with applicable occupational health and safety regulations for health care workers.

Education

The NACA Infection Control Program educational program is based upon practice or knowledge deficits identified through infection control rounds and daily activities of the infection control staff. The education program includes but is not limited to:

1. NACA Infection Prevention and Control Orientation and mandatory in-services
2. Policy and Procedure Review
3. Annual Skills Check

4. Infection Prevention and Control Measures (PPE, Isolation Precautions, Hand Hygiene, Disinfection and cleaning methods, Blood pathogen exposure, TB exposure prevention)
5. Educational methods will include presentations, emails, department meetings, written communication and/or verbally, educational trainings, professional development guidance, and Environment of Care or Infection Control rounds.

Influx

NACA has identified resources that can provide information on infections that could cause an influx of potentially infectious patients. Included among these are local, state, and federal public health systems. The table below provides contact information for various tribal, local, state, and federal public health systems. NACA utilizes methods which include email updates (internal and from external agencies such as Indian Health Services, Coconino County Health and Human Services etc), text, telephone, and visual alerts to communicate critical information to providers and staff about emerging infections that could cause an influx. NACA will respond to an influx by following protocol of the NACA Emergency Operations Plan Activation as initiated by an approved authority. NACA refers to Infection Control Policy: Outbreak Investigation, Influx Infectious Patients for addressing influx.

Resource	Telephone Number	Website
Coconino County Health and Human Services	**928-679-7272**	Health and Human Services | Coconino (az.gov)
Arizona Department of Health Services	**602-542-1025**	Arizona Department of Health Services (azdhs.gov)
Navajo Nation Public Health Service	**928-871-6350**	Navajo Nation Department of Health > Department > Division of Public Health Service (navajo-nsn.gov)
CDC	**1-800-232-4636**	Centers for Disease Control and Prevention (cdc.gov)

Outbreak Investigation

NACA investigates outbreaks of infectious disease occurring within the facility. The outbreak investigation process is found in Infection Control Policy (IC 150). The ultimate goal is to identify probable contributing factors and use that information to stop or reduce the risk for

future occurrences. NACA refers to Infection Control Policy: Outbreak Investigation, Influx Infectious Patients for addressing outbreaks.

Following an outbreak or influx response, the Infection Control Committee will conduct a post-event evaluation and integrate lessons learned into the IPC program and QI activities.

Infectious Waste

NACA minimizes the risk of infection when storing and disposing of infectious waste. Infectious waste handling and disposal procedures are fully covered in the facility's Handling/Disposal of Biohazardous Waste Infection Control Policy.

Transmission Based Precautions

NACA adheres to standard and transmission based precautions in response to the pathogens that are suspected or identified within the NACA setting and community. Transmission-based precautions are infection prevention and control measures to protect against an exposure to a suspected or identified pathogen. These precautions are specific and based upon the way the pathogen is transmitted. Categories include: contact, droplet, airborne, or any combination of these. NACA will refer to CDC regarding standard precautions.

NACA will provide personal protective equipment to follow universal and transmission based precautions including but not limited to hand sanitizer, soap/water, eye and face shields, gowns, masks, pocket masks/mouth guards, and gloves. NACA refers to Infection Control Policy Transmission Based Precautions for further guidance.

Respiratory Hygiene

NACA implements measures to prevent patients with respiratory infections from transmitting their infections to others. NACA utilizes the use of visual alerts, ensures the use of nose and mouth coverings for patients with signs and symptoms of respiratory illness, supply appropriate PPE and tissue with trash receptacles for disposal, encourage frequent hand hygiene, supply hand hygiene supplies, encourage social spacing from other person(s) in the vicinity. Further details are found in the Infection Control Respiratory Protection Policy.

Infectious Based Transfers

NACA will notify receiving organizations of any known infectious diseases requiring treatment upon transfer. If NACA becomes aware of an infection after a transfer, NACA will notify the

receiving organization as soon as possible as per Infection Control Policy Isolation of a Patient/Client.

Cleaning and Low Level Disinfection

NACA implements infection prevention and control activities when doing the following: cleaning and performing low-level disinfection of medical equipment, devices, and supplies. Policies regarding cleaning and disinfection can be found in Infection Control Policies Cleaning & Disinfecting Patient Care Equipment, Housekeeping & Custodial Services, and Cleaning & Intermediate Level Disinfection.

Employee Health

NACA implements a staff vaccination program that is offered to NACA employees. Offered vaccines include: Hepatitis B series, Influenza, MMR, Varicella, Tetanus, diphtheria, pertussis (Tdap), and Covid-19. NACA educates recipients about the vaccine, prevention measures, diagnosis, transmission, and the impact of diseases preventable by vaccination.

NACA implements a respiratory protection system which entails annual fit testing and education on the proper use of respiratory protection devices. NACA implements a post bloodborne pathogen exposure protocol that includes proper reporting, evaluation and treatment. Infection Control Employee Vaccination Policy and Respiratory Protection Policy further detail the employee health guidelines (IC 210 and IC 160).

Sharps Safety

In accordance with CDC recommendations, all healthcare personnel must strictly adhere to sharps safety infection control policy (IC 180) as part of the infection control program. This includes, but is not limited to, proper handling, disposal, and containment of sharps to minimize the risk of needlestick injuries and potential transmission of bloodborne pathogens. Training on safe sharps practices, use of engineered sharps injury prevention devices, and regular monitoring of compliance with sharps safety guidelines are integral components of our infection control program to ensure the health and safety of both patients and healthcare workers.

Construction and Renovation
Environmental Services

NACA refers to Infection Control for Construction and Maintenance Policy (IC 340) regarding infection control interim practices during construction or renovation to ensure the safety of staff, patients, and visitors. NACA will conduct a pre-project checklist, interim infection control safety measure checklist, and Infection Control Risk Assessment for all construction or renovations.

Annual Evaluation

NACA Infection Control Program evaluates the effectiveness of the infection prevention and control interventions and redesigns the infection prevention and control interventions to improve patient care. Review of goals vs outcomes, outbreaks/influxes, survey findings or drills, and identification of new priorities shall contribute to the annual evaluation. This evaluation occurs formally at least annually and when risks significantly change.

POLICY: HR 419	(X) Revision ( ) New	Original Issue Date: Revised Date: 03/24/17; 09/01/20; 09/01/23 Approved by: Board of Directors Approval Date: 07/19/17; 12/31/20; 10/07/23; 11/20/24; 10/15/25; Effective Date: 02/18/16; 07/20/2017; 01/01/21; 10/10/23; 12/02/24; 10/16/25 Annual Review Date: 10/15/26
Early Identification, Assessment, and Management of Suicide Risk	Author: Human Resources	

I. **POLICY:** The policy of NACA is to provide supportive, caring interventions and follow-up services through ~~screening,~~ assessment and ~~management~~ supporting of suicide risk of NACA employees, clients, and the general community. This includes ~~timely~~ immediate referrals to appropriate services, information, and resources that are evidenced based and best practices.

II. **PURPOSE:** To create a quality ~~consumer-centered continuum of care~~ structured framework for early identification, assessment and ~~management~~ supporting of suicide risk. To establish an appropriate protocol to be initiated in response to ~~screening results of a consumer~~ suicide. To offer appropriate evidence based and best practices care. To provide training and resources for a caring, confident and competent workforce. To assess ~~for~~ quality improvement via feedback loops and data collection.

III. **PROCEDURE:**

A. Protocol for Workplace Preparedness Training

- All NACA employees and new hires must receive mandatory training in suicide alertness through the safeTALK every year and Applied Suicide Intervention Skills Training (ASIST) every two (2) years. Exception to this policy may be approved by the ~~supervisor in collaboration with the CEO~~ HR. Employees who are affected by a recent experience of suicide will be excused from suicide training for a period of one (1) year. Employees are encouraged to seek NACA EAP services immediately upon an experience of suicide to cope with the grieving. Training for new hires should be within the first six (6) months of employment.
- <u>Annual training for all staff.</u> A copy of the Certificate of Completion for safeTALK and ASIST shall be placed in the employee's personnel file and monitored on annual basis by HR. NACA Behavioral Health (BH) staff will receive training in Collaborative Assessment and Management of Suicidality (CAMS) and Assessing and Managing Suicide Risk (AMSR). NACA Behavioral Health staff will receive training in Evidence-Based Care: Cognitive Behavior Therapy (CBT) for Suicide Prevention (CBT-s) and/or Dialectical Behavior Therapy (DBT). Due to Behavioral staff required to have additional suicide trainings, they will not be subject to the annual safeTALK and ASSIST training.

- Employees who are trainers for SafeTALK and/or ASIST will not need to complete the required training for which they were trained to be a trainer. Trainers will need to provide the recent SafeTALK and/or ASIST training certification to HR.

B. Consultation

- If, at any time, you have a concern or see signs of suicidality in employee or general public, Terros Health should be contacted immediately. ~~someone (employee or not),~~ If a patient, you have the option to contact BH for a consultation. Consultations are confidential; however, BH professionals may have a duty to report; your consultation will be kept confidential. ~~The BH Director or BH professional should be consulted to determine availability.~~

Vehicle Fleet Policy:

VFP 100 Use of Motor Vehicle
VFP 200 Fleet Fuel Card Usage

POLICY: VP 100	( ) Revision (X) New	Original Issue Date: 4/20/2026 Revised Date: Approved by: Board of Directors Approval Date: Effective Date:
Use of Motor Vehicle	Author:	

I. **POLICY**: The policy is to provide guidelines for employees operating NACA owned vehicles, rental vehicles, and/or personal owned vehicles when conducting business during or outside of business hours. Employees must adhere to the vehicle policy in reserving and approval, operating vehicles using safety, accountability, and cleanliness, and maintain the maintenance of the company vehicles.

II. **PURPOSE**: To encourage employees to be safe, accountable, and responsible drivers while operating and caring for company vehicles and/or rental vehicles during official business.

III. **QUALIFICATION REQUIREMENTS:**

A. Employees with a valid Arizona or other state driver's license and recent Motor Vehicle Driving Record from Arizona or other state MVD are eligible to operate NACA vehicles or rental vehicles. Both documents must be submitted to HR including the complete defensive driving course. All documents will be on file in the employee file in HR and the HR will provide the driving record to the NACA insurance carrier for approval to be an eligible driver.

B. Use of personal own vehicle must have prior approval by the immediate supervisor when a NACA or rental vehicle is unavailable. The employee will be eligible for mileage reimbursement pursuant to Finance procedures. Employees using their personal vehicle must provide evidence of valid automobile liability insurance policy with minimum uninsured and underinsured motorist coverage with a combined single limited liability policy as required by Arizona State law during approval of personal vehicle usage.

IV. **PROCEDURE**:

A. Employees should inspect the vehicle during usage for damage, headlights and taillights, windshield. tires, and any other conditions that may be a safety hazard. Any issues found with the vehicle should be reported to the immediate supervisor and the QI & Compliance Director.
B. All NACA vehicles should be locked and appropriately parked in a secure parking lot while on official business travel and/or in the front parking area of the NACA General Service Administration Office.
C. NACA vehicles have NACA decals which should not be removed or covered.
D. Employees must record the beginning and ending mileage on the mileage sheet while driving vehicles for business travel.

E. Employees and any passengers must fasten seat belts while driving company owned, rental, and personal vehicles.
F. No texting or using phone while driving.
G. Employees cannot use company vehicles for personal business or errands.
H. No unauthorized driver shall operate a company and/or rental vehicle.
I. Report any driving violations while operating a company and/or rental vehicle.
J. Report changes to driving privileges, such as driver's license suspensions, immediately.
K. Report any damage or issues to company and/or rental vehicle.
L. Employees cannot operate a company vehicle while under the influence of any medication that may impair his or her ability to operate a motor vehicle.
M. Smoking is prohibited in all company vehicles.
N. No employee shall operate a company vehicle under the influence of alcohol, a controlled substance, or other intoxicating substance/agent while operating a vehicle. Employees are responsible for any violations that occur because of any alcoholic beverages, controlled substances, or other intoxicating substances. Disciplinary action will result, including up to termination.

V. TRANSPORTING RULES:

A. Transporting non-employees including family members, while operating a company owned and/or rental vehicles is prohibited due to liability issues.
B. Transporting medical or behavioral health clients or patients by employees using personal vehicles is prohibited.
C. Community Development youth participants may be transported by NACA employees, only if all NACA staff driver eligibility requirements are met as specified in this policy.
D. Youth participant eligibility requires that the youth participant be actively involved in NACAs Pathway Youth Program. Participants must be under the age of 18.
E. Youth participants may only be transported in a NACA owned or rented vehicle. NACA staff are never authorized to transport youth participants in a staff vehicle.
F. Youth participation dissatisfaction, or parent/guardian dissatisfaction, shall be directed to the Program Manager of the respective program.

VI. REPORTING OF VEHICLE ACCIDENT:

A. Employees will report moving violations to the immediate supervisor, CEO, QI & Compliance Director, and HR Director within 24 hours.
B. In the event of a vehicle accident, employees will immediately report to the immediate supervisor, CEO, QI & Compliance Director, and HR Director to ensure the insurance provider is contacted to follow on exchanging information with the other driver.
C. Employees should call the local police to obtain a police report to submit to the insurance provider, if needed.
D. Employees must complete an Incident report within 24 hours and submit it to the QI & Compliance Director.

VII. MAINTENANCE CARE AND VEHICLE REQUIREMENTS

A. The CEO & Finance Division are responsible for routine maintenance for the NACA Fleet including the vehicle registration renewals and insurance coverages.
B. Employees should always park vehicles in designated parking.
C. Employees should keep vehicles clean when using.
D. Washing and cleaning company vehicles on a regular basis or as determined.

VIII. VEHICLE POLICY VIOLATIONS

A. Violations of this policy may be subject to disciplinary action, up to and including termination.

POLICY: VP 200	( ) Revision (X) New	Original Issue Date: 05/15/26 Revised Date: Approved by: Board of Directors Approval Date: Effective Date: Annual Review Date:
Fleet Fuel Card Usage	Author: QI & Compliance Director	

I. **POLICY:** The purpose of this policy is to establish internal controls, accountability standards, and operational procedures governing the issuance and use of fleet fuel cards for Native Americans for Community Action (NACA) vehicles and approved transportation activities.

II. **PURPOSE:** The purpose is to utilize the organization-issued fleet fuel card when NACA employees, contractors, and any non-employee operating NACA owned, rented, or approved vehicles utilizing organization-issued fleet fuel cards.

III. **DEFINITIONS:**

Fleet Fuel Card: A payment card issued by NACA or its choice of financial institution for authorized fuel and approved vehicle-related purchases.

Authorized User: An employee or approved personnel authorized to operate a NACA vehicle and utilize a fleet fuel card.

Organizational Vehicle: Any vehicle owned, rented, or otherwise authorized for NACA business operations.

IV. **PROCEDURE:**

A. The policy is intended to:
   - Ensure responsible stewardship of organizational resources;
   - Maintain compliance with federal, state, grant, and organizational requirements;
   - Reduce fraud, misuse, and unauthorized expenditures;
   - Promote safe and efficient vehicle operations; and
   - Support operational oversight and fiscal accountability

B. Fleet Fuel Cards: Are issued solely for authorized business purposes related to organizational operations. All cardholders and vehicle operators are responsible for ensuring purchases are legitimate, properly documented, and related to NACA business activities.

C. Authorize Uses:
   a. Fleet fuel cards may only be used for the following approved purposes:
      - Fuel purchases for NACA sanctioned vehicles;
      - Diesel Exhaust Fluid (DEF);
      - Motor oil and essential vehicle fluids, including maintenance related matters as approved by a supervisor.

- Emergency roadside vehicle supplies with supervisor approval;
- Vehicle-related emergency purchases authorized by Administration.

b. All purchases must directly support NACA operations and program activities.

c. Fleet fuel cards will not be used for:
- Personal vehicles;
- Personal expenses of any kind;
- Food, beverages, or snacks;
- Alcohol, tobacco, or controlled substances;
- Cash withdrawals or cash advances;
- Vehicle repairs without prior authorization;
- Non-vehicle-related merchandise or services;
- Purchases for non-NACA individuals or entities.

Any unauthorized transaction will require full reimbursement to NACA and will result in disciplinary action.

d. Card Issuance and Control
1. Fleet cards will be assigned by the Finance or Administration Department.
2. Cards may be assigned to a specific vehicle or designated personnel.
3. The Finance Department will maintain current inventory and tracking of all cards.
4. Employees must immediately report lost, stolen, or compromised cards.

e. Driver Responsibilities
Authorized vehicle operators are responsible for safeguarding the fleet card, recording accurate mileage and transaction information, obtaining receipts, operating vehicles safely, and reporting accidents or suspicious activity promptly and clearly.

f. Fueling procedures
At the time of each fuel purchase, the authorized user shall:
1. Use the assigned fleet card;
2. Record the date, vehicle identification number, odometer reading, and driver initials;
3. Obtain an itemized receipt; and
4. Submit receipts according to departmental procedures.

g. Receipt and Documentation Requirements

All transactions must be supported by original itemized receipts, odometer readings, vehicle identification, and program or department information if requested.

Missing receipts must be documented using an approved Missing Receipt Form and submitted to Finance Department.

h. Spending Limits
   The Finance Department will establish daily transaction limits, monthly spending limits, product restrictions, and geographic purchase restrictions.

i. Monitoring an Audit
   The Finance Department will conduct routine monitoring and reconciliation of fleet card transactions. NACA reserves the right to audit all fleet card usage and related records at any time.

j. Violations of Fleet Fuel Card Policy

   Violations of this policy may be subject to disciplinary action, up to and including termination.

NACA
NATIVE AMERICANS
FOR COMMUNITY ACTION

NACA
COMMUNITY DEVELOPMENT

NACA
NATIVE AMERICANS
FOR COMMUNITY ACTION

NACA
ECONOMIC DEVELOPMENT

NACA

NACA
Family Health Center
1500 E. Cedar Ave., Suite 26, Flagstaff, AZ 86004
(928) 773-1245

NACA

NACA
Family Health Center
1500 E. Cedar Ave., Suite 26, Flagstaff, AZ 86004
(928) 773-1245

NACA
Behavioral Health Center
1500 E. Cedar Ave., Suite 26, Flagstaff, AZ 86004
(928) 773-1245

NACA
General Services Administration
1500 E. Cedar Ave., Suite 56, Flagstaff, AZ 86004
(928) 526-2968

NACA
Behavioral Health Center
1500 E. Cedar Ave., Suite 26, Flagstaff, AZ 86004
(928) 773-1245

NACA
General Services Administration
1500 E. Cedar Ave., Suite 56, Flagstaff, AZ 86004
(928) 526-2968

NACA
Healing Together

NACA
Where Empowerment Happens

NACA
HEALTH PROMOTIONS

NACA
SUPPORTIVE SERVICES

NACA
PATHWAYS AFTER SCHOOL
FOR YOUTH

NACA
Wellness Center
1500 E. Cedar Ave., Suite 52, Flagstaff, AZ 86004
(928) 773-1245 ext. 221

NACA
REACH UR LIFE

NACA
Wellness Center
1500 E. Cedar Ave., Suite 52, Flagstaff, AZ 86004
(928) 773-1245 ext. 221

SACRED MOUNTAIN PRAYER RUN
FLAGSTAFF, AZ

SPRING INTO SUMMER HIKING SERIES
STRONG SPIRIT, STRONG HEART

L.I.F.E.
Lasting Indigenous
Family Enrichment

NACA

NACA

NACA
NATIVE AMERICANS
FOR COMMUNITY ACTION

NACA
NATIVE AMERICANS
FOR COMMUNITY ACTION

NACA
NATIVE AMERICANS
FOR COMMUNITY ACTION

NACA

NACA

NACA

NACA Financial Statistics
For the Year 2025

Current Ratio - Measurement of health. Current asset is the most liquidable to turn into cash to pay off current liabilities, if need be.

Current Assets	14,139,762	
Current Liabilities	3,799,488	
	3.72	Healthy ratio.

Quick Ratio - the quickest measurement of health. This is the ratio of current assets, minus the right to use asset, divided by current liabilities.

Current Assets Minus Asset Right to use	14,014,458	
Current Liabilities	3,799,488	
	3.69	The most liquidable assets cover our current liabilities.

Cash Ratio - cash and cash equivalents divided by current liabilities. This is a measurement of the list liquid asset, cash, and its coverage of current liabilities.

Cash and cash equivalents	11,686,998	
Current Liabilities	3,799,488	
	3.08	Coverage of cash over current liabilities.

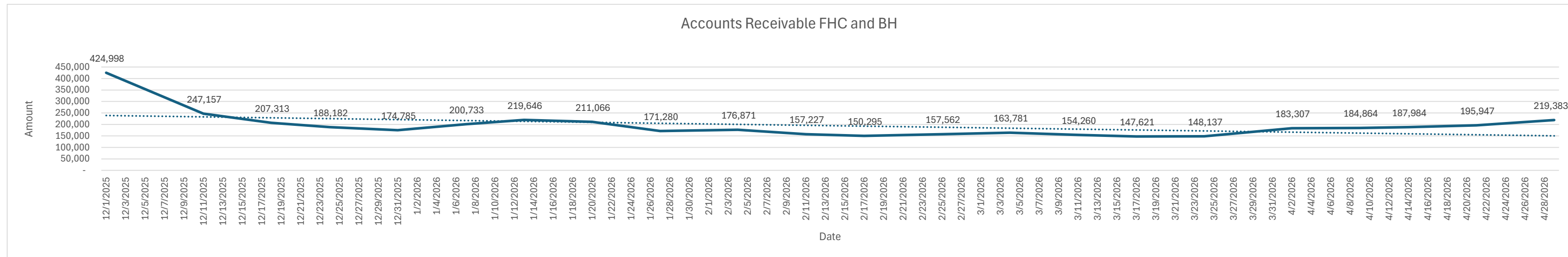
Debt Coverage Ratio - with no debt, all assets belong wholly to NACA.

Accounts Receivable - December 2025 to March 11, 2026

Trending upward in May 2026 with a decrease in cash inflows on a weekly basis.

	12/1/2025	12/11/2025	12/18/2025	12/24/2025	12/31/2025	1/7/2026	1/13/2026	1/20/2026	1/27/2026	2/4/2026	2/11/2026
	424,998	247,157	207,313	188,182	174,785	200,733	219,646	211,066	171,280	176,871	157,227
Percentage		-42%	-16%	-9%	-7%	15%	9%	-4%	-19%	3%	-11%

	2/17/2026	2/25/2026	3/4/2026	3/11/2026	3/17/2026	3/24/2026	4/2/2026	4/9/2026	4/14/2026	4/21/2026	4/29/2026
	150,295	157,562	163,781	154,260	147,621	148,137	183,307	184,864	187,984	195,947	219,383
Percentage	-4%	5%	4%	-6%	-4%	0%	24%	1%	2%	4%	12%



CEO AND NACA
PROGRAM REPORTS

Monthly Meeting of the NACA Board of Directors
CEO Report May 2026

Key Highlights:

- Open Drum, 6:00pm – 8:00pm, April 14th – 28th and May 12th.
- Aambe Health Pharmacy Discussion, April 13. 2026
- AACHC Annual Conference, April 14, 15, 16, 2026, Scottsdale, AZ.
- Board Candidate Meet & Greet - Skyler Bordeaux, April 21, 2026
- SMPR Meeting, April 21, 2026.
- HRSA and RAZ Chow meeting placeholder, April 22, 2026
- NAU and NACA Flash Training, April 22, 2026.
- Aambe Health Site Visit ant NACA, April 23, 2026.
- NCUIH Conference in Washington Dc, April 16th – May 1st.
- SMPR Meeting, May 4, 2026.
- MMIP Awareness Day, May 5, 2026.
- Meet and Greet Banner PT, May 6, 2026
- Cinco De Mayo Salsa competition, May 7, 2026.
- Clinical informatics for HIV prevention study meeting, May 8, 2026.
- AACIHC Tribal Convening, May 11, 2026.
- Grants Committee meeting, May 12, 2026.
- AVAN Mobility (Demo Walkthrough) – May 14, 2026.
- Joe Martinez/Joe Herrera Kiva Capitol meeting, May 15, 2026.

Current and Ongoing Activities:

- Developing leadership curriculum based on Indigenous values/concepts.
- We will continue to meet regularly with directors and leadership twice a month, alternate weeks.
- Meet with Marketing/Advertisement officer to discuss strategies, weekly.
- Participation on NACA committees (Workplace/Community SMPR, Employee Retention)
- Finance Committee meeting with CFO and Board of Directors.
- Meeting with NACA Board of Directors weekly, Fridays, 10am.
- I H S Exit conference audit 2024-2025, pending.
- Open Drum: every two weeks, Tuesdays at 6:00pm to 8:00.

Meeting/Events:

- CHW Roots, June 25-26, 2026, Chandler, AZ
- NTHC Conference, August 17-21, 2026, Chandler, AZ.
- NextGen UGM Oct/Nov, San Deigo, CA.

Respectfully submitted: Chris David, CEO, NACA

NACA Board of Directors Monthly Meeting Update

Agenda

- **Billing Program**
  - **Clean Claims to the clearing house.**
  - **NextGen Tools**
    - **LUMA**
      - **Implementation the week of May 11, 2026**
    - **Instamed**
    - **Waystar**
  - **~ 30 visits per day per biller**
    - **Release of claims**
      - **Daily. Currently, the lag time is 6 days.**
    - **Collections of AR**
    - **Denial management**
      - **22% denial rate**
  - **Credentialing**
  - **Accounts Receivable**
    - **12/1 - ~ 400k**
    - **Mid Jan 2026 – 200k**
    - **Mid Feb 2026 – 170k**
    - **March 2026 – 151k**
    - **April 2026 – 180k**
      - **Change in HIM – AR work back to normal**
      - **Need to focus on clean claims and getting to the clearing house.**
      - **Contracts.**
- **Financial Close and Grant draw down/cash**
  - **Financials closed on a 15 day cycle.**
- **Insurance and Brokers**
  - **Professional and General Liability-Crest Insurance**
  - **Directors and Officers – Crest Insurance**
  - **Medical – Crest Insurance**
  - **Workers Comp – Crest Insurance/ADP**
  - **MED/MAL – Crest Insurance**
      - **Coverage of Medical providers and NACA.**
      - **Coverage for BH is separate.**
- **Medicare cost report**
    - **Peer consultation**
    - **Due 5/31/2026**
    - **Engage with Forvis Mazars.**
- **Medicaid Payable.**
  - **Choice to leave a liability on the balance sheet.**
  - **Medicaid unaware idea from communication.**
    - **Baker Tilly chose to leave as a liability though the chance of payback is slim.**

- **Medicaid Rate**
  - **The decrease was ~ $180 per encounter starting on 10/1/2025.**
  - **Discussion with the Alliance and Medicaid was to work on maximizing the next rebasing period.**
  - **Reconciliation upcoming of ~ 65k.**
- **Audits**
  - **Grant Audit – 2025 to begin June 2026.**
  - **Financial Audit – 2025 to begin June 2026**
- **Wells Fargo – there are four major changes upcoming.**
  - **Credit cards – we are migrating to a higher level of service. A portal is provided to us that will allow real time changes, such as cancelation, credit limit changes, and charge blocks. In process as of 5/14/2026**
    - **Additionally, Wells Fargo will deduct from our account the value of credit card transactions from all users. So, the payment is automatic.**
  - **Sweeps – We are being moved to a daily sweep that earns returns and will cover all fees and more.**
  - **Investments – we are looking into how we can utilize our funds and capitalize.**
    - **Investment policy. Three prong approach.**
      - **Long term investment portfolio.**
      - **Mid term fixed to a certain goal.**
      - **Short term sweeps.**
  - **Treasury management – with the 'vantage' online portal and having access we can perform banking steps in real time.**
- **Next/Gen**
  - **Collaboration with Next Gen.**
  - **More robust cash processing, data capture, and process flow.**
  - **Streamline process for accounting and revenue capture.**
- **Revenue Generating Maximization**
  - **Overlook**
  - **Pharmacy**
  - **Xray**
  - **Phlebotomy**
  - **Mobile services**
  - **Physical Therapy**
  - **Chiropractic**
- **IDC**
  - **2024 impact from incorrect rate and incorrectly billing to a Grant.**
    - **~ 500k**
  - **Provisional at 17.6%**
- **Marketing**
  - **SMPR**
  - **Overlook**
  - **NACA**
- **Grant Mangement, Tracking, and compliance**
- **Banking**
  - **Native American Bank**
  - **Sunwest Bank**
  - **Columbia Bank**
  - **JP Morgan/Chase**
  - **New Market Tax Credits**
- **Auditor**
  - **Baker Tilly**
  - **WIPFLI**

- **Forvis Mazars**
- **Walker and Armstrong**

Human Resources
May 2026 Meeting-Board Report

Major Highlights

- The HR Technician attended the SafeTALK training on April 17, 2026, to comply with the mandated training.
- Attended the board meet & greet on April 21, 2026, with candidate, Skyler Bordeaux, Board members and Chris David, CEO. Skyler is the newest member selected.
- Interviews were conducted for the Fitness Specialist, Community Health Representative, and Grand Canyon Ranger.
- Continuing with the Relias overview with training representatives regarding the modules for competency training. The team is training on regulation management, policy pro, and incident pro in the month of May and June. The full transition from HealthStream will be in January 2027.
- The SMPR meetings are ongoing with staff for the annual run event on June 6, 2026.
- Attended the QI meeting on April 23, 2026, and the Operations meeting on April 24, 2026.
- Attended the MMIW Awareness Day on May 5, 2026, held by Health Promotion. A wonderful event with City of Flagstaff Mayor Daggett and her staff members in attendance as well as other community members from Flagstaff and other areas from the reservation. Good turnout for the walk to honor MMIWP. It was the largest amount of attendance compared to previous years.
- Eight (8) providers are preparing for the two (2) year re-privileging and re-credentialing this month and will be provided to the MedEx Team in June for approvals.
- Directors and managers are working on staff evaluations which are due on May 20th. HR will review and prepare for merit pay during the first payroll in June.
- The retention committee is continuing to plan for the annual staff retreat and annual open house. A survey for the staff retreat was sent out to staff for recommendation for training topics, activities, menu, and location to have the retreat. The committee will review the survey at its scheduled meeting on May 27th. The scheduled date for the staff retreat is August 6th and the open house on September 10, 2026.
- One (1) insurance benefit enrollment was processed this month for an eligible employee on their 60th day of employment.

Current Activities

- Recruitment activities are on-going for vacant positions.
- Continue to prepare and work on the AAAHC, ADHS, and IHS site visits including policy review.
- Continue monthly meetings for the following: director, leadership, MedEx, QI & Compliance, HealthStream & Relias training modules, SMPR, tenured staff survey (5+ yrs), employee benefits, and the retention committee.

Vacancy Listing

	Family Health Center	
1	Medical Director/Physician	1/9/2026
2	Physician	New
	Health Promotion	
3	Community Health Representative	New
4	Fitness Specialist	3/31/2026
	Community Development	
5	PT Overlook Ranger	10/31/2025
6	Overlook Ranger	4/6/2026

Month: April 2026
Program: Community Development
Staff: Dorothy Denetsosie Gishie, Director
Date: May 13, 2026

Program Monthly Highlights:
Division Director: Dorothy Denetsosie Gishie
Community Development Program Monthly Highlights:
Weekly Directors and Leadership meetings provided ongoing coordination, alignment, and updates across programs, strengthening communication and supporting consistent implementation of organizational priorities.
Key activities during this period included planning for the Sacred Mountain Prayer Run with a focus on cultural grounding and community wellness. I continued work through staff and community support committees, and participation in public safety and Indigenous advisory efforts to ensure community-informed and culturally responsive decision-making. Additional engagement included collaboration with the Arizona American Indian Tourism Association to support Indigenous tourism and economic development, outreach through a Desert Financial Credit Union tabling event to share program resources, and ongoing operations meetings to improve workflow and program delivery.
I also contributed to external partnerships and community engagement by serving as panelists with Northern Arizona University Marketing Class, I supported the Grand Canyon Ranger recruitment interviews and participated in MMIR Awareness Day activities focused on advocacy, remembrance, and community education.

The Economic Development Program:
Program Coordinator: Pearl Tsosie
Staff: OL & Grand Canyon Rangers: Jensen Lanzo, Tyrell Tsinnie, Jennifer Shelton
During April 2026, community event operations focused on the monthly vendor lotteries for Overlook Vista, the Grand Canyon Visitor's Center, and the Tusayan Museum, with more than 150 vendors participating. Staff managed three lottery rounds and completed payment and permit reconciliations. Vendor participation remained strong, with the Grand Canyon Visitor's Center selling out, Overlook Vista reaching 80% capacity, and the Tusayan Museum reaching nearly 85% capacity.
Collaboration with the Coconino Forest Service continued through meetings regarding parking lot repairs, signage updates, and monitoring prescribed burns near Overlook Vista. Road construction in Oak Creek Canyon impacted visitor traffic, while both the Grand Canyon Visitor's Center and Tusayan Museum continued to experience high visitor activity and increased vendor participation throughout the month. Additionally, the Program Coordinator terminated a staff member, and the program is currently in the process of announcing the position and interviewing prospective candidates.

Reach UR Life (RUL) Program:
Program Manager: Onelia Soto:
Staff: Shoshana James, Angelina Tso, Anya Ashley
The team is winding down student-led activities as the school year comes to a close while continuing to maintain strong relationships with school personnel and partner organizations in preparation for the next school year. The Health First Foundation application was submitted, and the team received a positive response and an invitation for an interview with the CEO to address clarifying questions. Staff met to align on anticipated questions and ensure consistent, well-prepared responses across the team.
Group sessions with students are ongoing and continue to be well received. The team is also preparing to facilitate another ASIST training for community members. The Program Manager and staff maintain daily check-ins for coordination and hold weekly meetings to support collaboration, planning, and program alignment.

Pathways Program:
Program Coordinator: Kateri Slim
Staff: Joi Lynch: Recreational Assistant
Pathways staff and students attended the 13th Annual ITRE Conference at the University of South Florida, where Kateri and Joi presented their revamped Beauty Way Curriculum research project. NACA was recognized for its strong community partnership, and staff and students were invited to return next year.
Pathways participants participated in sportsmanship and team-building activities that strengthened communication, teamwork, and conflict resolution skills, while maintaining an exceptional 99% attendance rate. Pathways also partnered with Soaring Eagle Healthcare on a community service project supporting Navajo and Hopi elders through student-designed donation buckets. The program continued implementation of the Beauty Way curriculum and weekly collaboration with the NACA HP/LIFE program to provide health and wellness education. The program is going strong and getting ready for its summer program implementation.

Supportive Services Program:
Supportive Services Case Manager: Selena Holgate
The Supportive Services Program continues to demonstrate its greatest strength through strong collaboration with community resources and partner organizations. These partnerships are essential in maximizing opportunities to meet the diverse needs of clients and ensuring individuals and families have access to a wide range of supportive services. By maintaining effective relationships with community agencies, the program can strengthen service coordination, improve referrals, and provide more comprehensive support to those in need.
Supportive Services staff continue to maintain a consistent weekly presence within the community to assess client eligibility, provide outreach, and connect individuals with available resources and basic needs assistance. Staff also assist with navigating the distribution workflow to ensure services and supplies are delivered efficiently and appropriately to clients.
In addition, the program continues to foster a supportive and inclusive work environment where staff are encouraged to step forward, contribute ideas, and participate in leadership efforts. This collaborative approach strengthens team engagement, promotes shared responsibility, and enhances the overall quality of services provided to the community.

Leadership Coordination: Weekly Directors and Leadership meetings provided essential updates and guidance to advance program goals.
Meetings/Activities:
Sacred Mountain Prayer Run meeting are being coordinated by the committee chairs.
Workplace and Community Support Committee, Public Safety Citizen Committee, Indigenous Advisory Committee, Az American Indian Tourism Association meeting, Tabling event for Desert Financial Credit Union, Operations Teams meeting, NAU Marketing and Management Presentation Panelist, Interviews for Grand Canyon Ranger, MMIW Awareness Day activities,

Community Development Department Board Report
Submitted by: Selena Holgate Supportive Services Case Manger
April 2026

Community Events:
Community outreach to Flagstaff Family Food Center, Flagstaff Shelter Services, Crowns Traditional House, Taylor House. Mountain Line. Inter- Tribal Council of Arizona.

Collaborations:

- **Flagstaff Shelter Services** – Continue to provide on-site visits, and to clients that have not signed up for intake. And I follow up with clients on site. Distributed twenty bags of hygiene and PPE bags.
- **Continuum of Care meetings - T**hese are quarterly meetings; the next meeting planned for May 2026. At the meeting staffs provided updates from other programs.
- **Coconino Case Conference –** Attend weekly meetings on Thursday's. We continue to discuss our clients' referrals, and we provided updates at the meeting.
- **Advocates for Unsheltered Relatives** - No meeting for the month of April 2026 on the RARE Assessment.
- **Flagstaff Family Food Center: Hot Meal Services** - Provided on-site visits. Disseminated PPE supplies and hygiene bags. Distribute basic needs supplies: Backpacks, Jackets, Beanies, Gloves, and socks.
- **Crowns Traditional House -** Continue to provide on-site visits and follow-up on clients have not signed up for intake. I usually have conversations with individuals on site. And provided PPE to clients. No request for services.
- **Pathway-** Continue to provide collaboration with the Pathway Program Coordinator.
- **Taylor House** – I have submitted the Memorandum of Agreement 2026 (MOA) between the Northern Arizona Healthcare Corporation, and The Taylor House and Native American for Community Action, Inc. The purpose of establishing a mutual agreement is to exchange funds for services related to payments for patient lodging.
- **Mountain Line –** The Mountain Line Social Services Agency Discount Fare Program Agreement is in placed to purchase Regular Day Bus passes. To help families and individuals become stable and more self-sufficient.

FUNDS:

- **April 2026** -
- **Program 1980 (Supportive Services)** - Continue to provide services when client requests for education enhancement, utility assistance, rental assistance, and burial assistance. Submit requisitions for regular day bus passes, better bucks. And basic needs for unsheltered relatives. Distributed six shoes, 232 regular day bus passes and assisted with one food & gas card. Distributed 257 better bucks for February 2026. Distributed sixty-one hygiene bags and PPE.
- **Program 7014 (NCUIH Indian Health Services)** – We continue to have face masks available, and hand sanitizer supplies on hand at GSA.
- **Pathways** – No outreach for the month of April 2026.

HIGHLIGHTS:

- **The Inter-Tribal Council of Arizona, Inc**. - Area Agency on Aging (ITCA-AAA), Region 8 donated sleeping bags, tents, and backpacks to Native Americans for Community Action, Inc. (NACA), to be

use for homeless, older adults in Flagstaff, Arizona. I continue to distribute sleeping bags, tents, and backpacks. I requested backpacks for the back-to-school event, and it is confirmed for the sixty backpacks. And net working with the director.

- **Flagstaff Shelter Services** – Follow up if there are any clients who sign up for NACA Services intake. Continue to disseminate basic needs to unsheltered relatives. Distributed 24 PPE bags.
- **Food Bank** - Continue to provide on-site visits and to do outreach on 4/2/26, 4/7/2026, 4/9/2026, 4/14/2026, 4/21/26 and 4/29/2026. Distributed basic needs supplies: hoodies, shoes, beanies, gloves, socks, Hygiene bags, and PPE bags.
- **Crown Traditional House** - Follow up if there are any clients who sign up for NACA Services intake. Distributed 16 PPE Bags and Hygiene Bags. For the month of February's outreach.
- **Cats Bus** - Distributed basic needs supplies for unsheltered relatives. Distributed 20 PPE and 20 Hygiene Bags.
- **Desert Financial** - No sleeping Bags distributed.
- **Meetings –** I usually attend the leadership meetings, workplace community support committee meeting, operations committee meeting, and I usually provide update on Supportive Services.
- **NACA GSA Strength** – The staff(s) engage with the community, sharing their passion, and representing NACA with excellence. We continue to open our doors; it reflected the heart and dedication that drives our work every day. staff teamwork, energy, and commitment truly made the day memorable.
- **Challenges** – We are still waiting for the Memorandum of Agreement (MOA with FMC – Taylor House). The MOA has been reviewed by the NACA legal team, and the substantive content appears thorough and complete, and we did not make any substantive changes. We only corrected a few minor spelling and grammatical errors and adjusted the formatting for clarity.

I continue to be active in spending time. And the *Weather has been cool". And it has not impacted on resource navigation and distribution during this reporting period. Social Supportive staff continue to have a regular weekly presence out at the community to check for community client eligibility. Provided basic needs to clients and navigate distribution of the workflow. Participating in the leadership in fostering a supportive and inclusive environment where we continue as staff feel encouraged to step forward and contribute.

Respectfully submitted,

Selena Holgate

Supportive Services Case Manager
Pronouns: She/her/hers
Native Americans for Community Action, Inc.
1500 E. Cedar Ave., Suíte 56
Flagstaff, Arizona, 86004
Ph: (928) 526-2968 x 139
Email: Sholgate@nacainc.org
Website: www.nacainc.org

Board Report
Economic Development Program
Submitted by Pearl Tsosie
April 2026

Community Events:

The Community Event for the past month April 2026 was the monthly lottery, which was held on Sunday, April 12, 2026, for the Overlook Vista, Grand Canyon Visitor's Center, Tusayan Museum. We had over 150 vendors in attendance to take part in the monthly lottery. There was also the second lottery, and the third lottery. Three lotteries like that, it takes all day into the evening. Alicia and Darrell returned the next day on Monday to complete the balance of the monies and credit card receipts and checking if all days were sold right and to the right permit holder. That is another logistics matter all in its own, but we managed to get it done for the month of April.

The monthly lottery April 2026. The Grand Canyon Visitor's Center sold out, as usual, and with the Overlook not too far behind at 80%. The Tusayan Museum came close to selling out for the month of April 2026, at about 85% sold.

Collaborations:

- **Forest Service** Our communication with the Coconino Forest Service has been steady, since we need to make some repairs on the parking lot and signs that need to be updated. There are some prescribed burns in the area near the Overlook Vista, but not that much of a problem for now. Lots of road construction down the Oak Creek Canyon, which has been a barrier to people coming to visit the Overlook Vista.

- **The Grand Canyon Visitors Center and Tusayan Museum**
  The Grand Canyon Visitors Center is always busy, starts early in the morning into the late afternoon. Very busy place, we are fortunate to get that site for the Vendors.
  The Tusayan Museum is busier than usual. More visitors are coming around, so the Vendors have been purchasing more space there. For the month of April, it was about 80% full by the end of the month.

Economic Development Program

We are getting ready for another Orientation for June 9, 2026. We have space for 20 people. I am sure we will fill the room.

We have 2 Rangers at the Grand Canyon and 2 temp people for the Overlook and working to fill the positions. The 2 Ranger positions at the Grand Canyon are only until October 31, when the sites will close for the season.

We hope to be filling the Overlook positions soon.

Overall, the Economic Development Program is still here to survive. As long as people are still interested in the Southwest the Program will be here to serve the people.

RUL Team - Board Report - April, 2026

1. **Vacant Positions -** Community Training Coordinator - Position remains vacant. We will need to fill this position, minimally, part-time, when we are awarded a grant.

    1. **Training that has been scheduled** -
        - Lifeskills
            - Coconino County Juvenile Dentention – 5/20, 5/27

2. **Intakes - Angie** - 2 intakes for month of May

3. **RUL Team Meetings** -
    - Monthly Meetings with RUL Team and Partners - These will continue to provide updates on partnerships and services. Our meetings are now in person every other month.
    - RUL Team meetings – These are continuing with daily check-in meetings, weekly collaboration meetings, and monthly meetings.

4. **Grant opportunities for RUL** -
    - Health First Foundation Northern Arizona – Grant application was submitted 02/20/26. RUL was invited to a ZOOM meeting with Health First Foundation on May 13, 2026. RUL team members, along with Dorothy and Chris, participated. RUL provided an overview of the program proposal.

    - RUL submitted the application for the Arizona Community Foundation Flagstaff on April 22, 2026.

    - Tony Robbins Foundation – Application was submitted 03/06/26. We have not received any status notification (approved or denied).

5. **Update With Partners/Community**
   the application for the Arizona Community Foundation Flagstaff

    - RUL is providing space for Phoenix Indian Center focus groups on May 16, 2026 from 8:30 am to 1:30 PM
    - RUL will be participating in De-Stress Fest presentation at Coconino High School Thursday, May 14,2026
    - RUL has resumed Mental Health Breaks every two weeks.

Month: April-May
Program: Pathways Youth Program
Staff: Kateri Slim, Joi Lynch
Date: May 7, 2026

Program Highlights

- **Pathways staff was invited to attend the 13th Annual ITRE Conference hosted by University of South Florida. Students connected to our program proudly presented their research project focused on the revamped Beauty Way Curriculum they developed throughout the year. NACA's involvement as a community partner was well received, and the program was recognized for its strong engagement and collaboration. Pathways staff and students were invited to participate again next year.**

- **Pathways students also participated in sportsmanship-focused activities and lessons. Through team-based games and court activities, students practiced communication, respect, teamwork, and conflict resolution skills. These activities provided students with positive opportunities to learn how to appropriately resolve issues on the court while encouraging healthy peer interactions.**

- **Pathways collaborated with Soaring Eagle Healthcare, a program that supports elders across the Navajo and Hopi reservations by assisting with basic needs. Students were provided blank buckets and encouraged to creatively paint and design them. These buckets will later be filled with supplies and distributed to elders throughout the reservation, allowing students to participate in a meaningful community service project while expressing creativity and cultural care for elders.**

Program Lows

- **No challenges or barriers to report during this period.**

Client Engagement & Attendance

- **Pathways continue to demonstrate exceptional engagement, maintaining a 99% attendance rate among participants.**

Client Services Provided

- **Ongoing implementation of the Beauty Way curriculum, supporting holistic youth development.**
- **Weekly participation from the NACA HP/LIFE program, providing supplemental health and wellness education.**

Network Meetings & Collaboration

- **SMPR Meeting – April 6 & 20**
- **NACA Leadership Meeting – April 23**
- **Workplace and Community Support Committee Meeting – April 7**
- **Grant Committee Meeting – April 7 and 14**
- **One-on-one meeting with Dorothy Gishie, Community Development Director – April 1**

Program Trainings

- **Joi Lynch successfully completed ASIST (Applied Suicide Intervention Skills Training) on March 30–31, strengthening the program's capacity to support student well-being and crisis response.**

April 2026 Marketing Report

Marketing goals

Increase community outreach and engagement, increase event attendance, and in turn, raise funding for NACA.

Current marketing strategy

1. Consistent social media posting using the social media content calendar, with daily themes for posting. Responding to comments and messages promptly and thoroughly.
2. Send NACA e-newsletter to all subscribers every 2 months. Occasional funding emails.
3. Promote NACA and departmental events/programs on social media, the website, in the e-newsletter, at public outreach events, in public media outlets, and via printed materials. Take photographs at NACA special events.
4. Collaborate with other organizations that can partner with NACA to further community outreach and engagement, and funding.

Completed Trainings/Webinars –

Completed Tasks

NACA Tasks

Open Drum Group

SMPR planning

Annual reports

Grant committee meeting

Flagstaff International Film Festival tribute planning

Communityshares planning

MMIW event planning

Bluebolt campus advertising

Redemption counseling center services

Alzheimer's association flyer share

Recreating QR codes on Canva

Basketball association scholarship

Tabling at Walk for wellness

Open house planning

Department Tasks:

Family Health Center –

Patient centered medical home infographic

Behavioral Health –

Business cards for general medication

Health Promotions -

Cooking class

What can I eat class

Newsletter and Calendar

Beading Circle

Gardening event

Spring into summer hiking series

Pathways – Summer Series flyer

Community Development –

Economic Development –

Supportive Services –

RUL – safeTALK and ASIST

safeTALK

website page revision

recreating registration form on surveymonkey

marketing meetings

QPR training

Ongoing Tasks:

KTNN & KUYI Radio advertising campaign

April 2026 Marketing Report

AZDaily Sun digital advertising campaign

Kind Traveler partnership

Leadership meeting

Directors meeting

Board of Directors meeting

Workplace and Community Support Committee meeting

Business Cards

All-Star Employee Recognition

Website maintenance

Monitoring Outreach email inbox

Promoting Oak Creek Overlook and Grand Canyon vending sites on social media

All Staff Calendar

Facility Communication boards

PatientPoint TVs

Social media reposts

QI/QA meeting

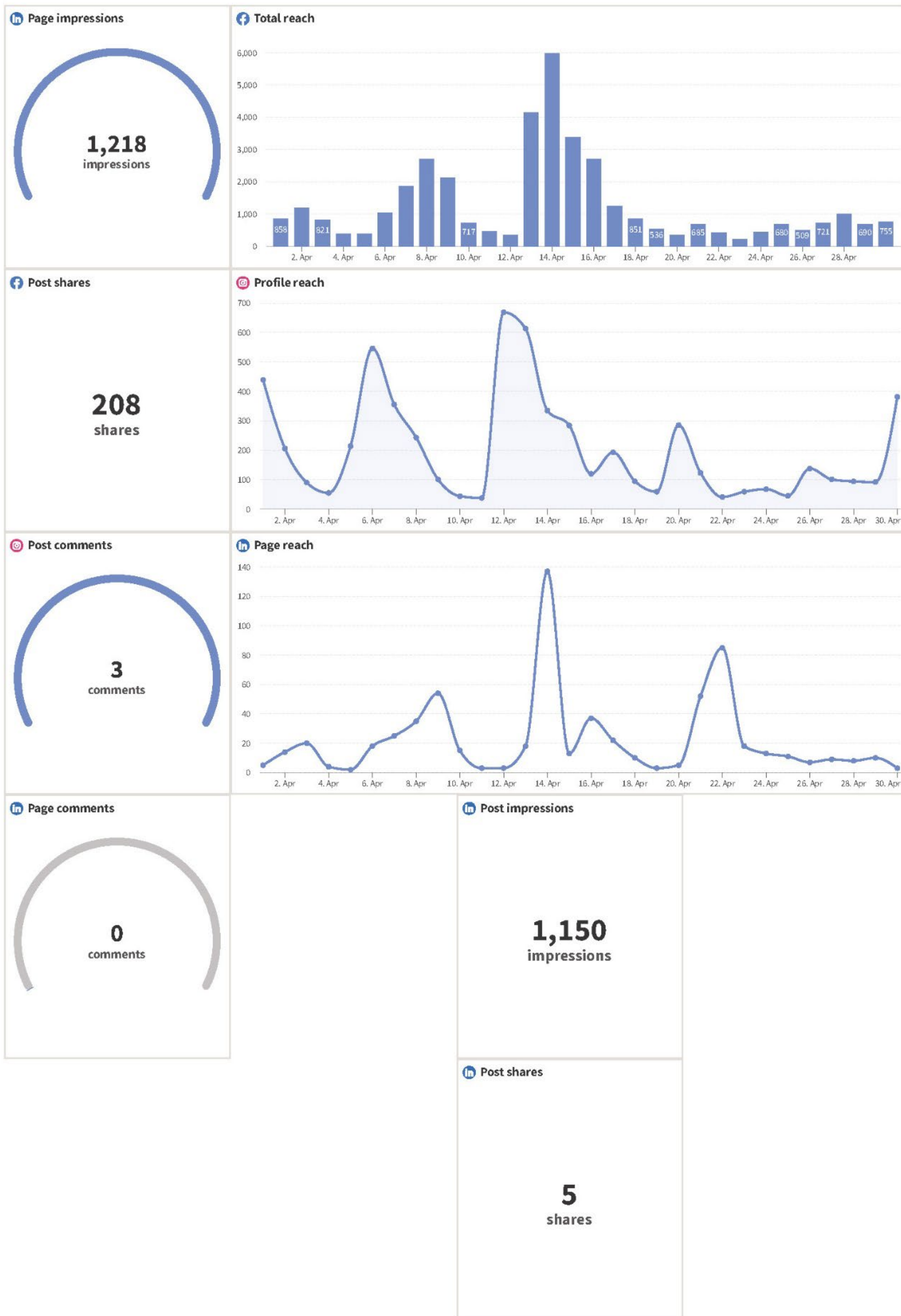
Strategic Planning Committee

…..and more!

Use the Linktree below to find NACA on Social Media:

https://linktr.ee/NACAFlagstaff

April 2026 Marketing Report



NACA
NATIVE AMERICANS
FOR COMMUNITY ACTION

NACA Quality Improvement & Compliance

Board of Directors Report | May 2026

Francisco Rendon, QI & Compliance Director

Section 1: Highlights & Challenges

Major Highlights

- **Relias:** Onboarding is in progress; rollout will be announced in the coming months.
- **Safe Injection Practices Audits:** Data collected in May 2026 will be reported in June 2026.
- **Peer-to-Peer Reviews:** Completed in May 2026; formal results will be reported at the June Board meeting.
- **IHS / HIS Support:** IHS has resolved multiple technical issues in NextGen and has been responsive and helpful.
- **Incident Reports (April):** Overall volume improved compared to the prior period.
- **LUMA Is Live (May 12):** Our new patient communication and appointment reminder system went live on May 12. This directly supports our No-Show Reduction PIP and will improve appointment completion rates and diabetic outreach going forward.
- **Patient Satisfaction Above Baseline:** March 2026 patient satisfaction scores reached 4.86 out of 5 — the highest recorded across any period, surpassing the 2025 annual baseline. Multiple care domains scored a perfect 5.00, and all eight March respondents said they would recommend NACA.
- **Positive Safety Indicators:** Zero medication errors, zero patient injuries at the facility, and mandated reporting was executed fully and on time. Staff injuries were reported same-day and defective equipment was immediately removed — reflecting a culture of accountability and timely response.

Major Challenges

- **IHS Exit Meeting:** Rescheduling is pending following the IHS site visit; the final report has not yet been received.
- **FHC Incident Spike:** A higher-than-expected concentration of incidents occurred in the Family Health Clinic during this reporting period.
- **Glycemic Control Data Integrity — EHR Reporting Error Identified and Corrected** During the Glycemic Control Subcommittee review, we discovered that the diabetic non-compliant patient list being pulled from the EHR was not accurately reflecting actual patient status — some patients flagged as non-compliant had already completed their A1C or were being managed elsewhere. Our HIS staff and DOO caught the error and developed a corrective workflow. The fix is in place, but we'll need to monitor it over the coming months to confirm the data is pulling correctly before we can fully trust the numbers driving our outreach decisions.

Section 2: Compliance & Risk Management

Accreditation & Regulatory

- **IHS Site Visit:** Completed February 20, 2026. Awaiting final IHS report. The Exit Meeting is currently being rescheduled.
- **AAAHC:** NACA is ACCREDITED. Accreditation period: December 9, 2025 – December 9, 2027.
- **ADHS:** Application has been updated. No further updates at this time.

Risk Management — Staffing & Hiring

- HISS and HIS positions filled in Health Information Management (HIM).
- Third FHC Clinical Medical Assistant (CMA) hired.
- Medical Director position filled; second physician hired.

Annual Policy Reviews

Due May 2026: Laboratory Services (LS) and Infection Control (IC) — see attached policy summaries and revised plans for Board review and approval.

Due June 2026: Medical Services (MS) and Quality Risk Management (QRM) — review will be presented at the June Board meeting.

- **IC Annual Policy Review:** See attachments IC.Policies.Annual.Review.Change.Summary.5.26 and IC.Plan.Revised.Change.Summary.5.26 for details.
- **LS Annual Policy Review:** See attachment Lab.Services.(LS).Policies.Annual.Review.Change.Summary.5.26 for details.

Section 3: Incident Report Summary

Reporting period: April 8 – May 13, 2026

16 Total Incidents Apr 8 – May 13, 2026	2 Staff Injuries Both reported same-day	1 VAERS Filed Vaccine adverse event	1 HIPAA Review PHI breach under review

Incident Category	Count	Department
Emergency	2	FHC / Admin
Patient / Member Safety	1	Behavioral Health
Patient Behavior / Policy Non-Compliance	4	FHC
Documentation Error	3	FHC
Staff Injury / Needlestick	2	FHC
HIPAA / PHI Breach	1	FHC
Vaccine Adverse Event	1	FHC
Patient Complaint (PCC)	1	FHC
TOTAL	**16**	

Key Themes

Documentation Errors

Front-desk scheduling and documentation errors continued in FHC — three incidents were traced to incorrect provider assignment or visit type entry. The PSC 4-point check protocol remains under active reinforcement.

Patient Behavior — Pain Management

Two incidents on 4/20 stemmed from a single encounter in which a patient refused the established pain management care plan, declined required labs, and exited with verbal litigation threats. Staff responded professionally; IHS referrals were re-sent.

Staff Injuries: A provider fell from a defective exam stool on 4/22 (arm and head impact); the defective equipment was immediately removed. A needlestick occurred on 4/24 with no injury and proper sharps protocol was followed. Both incidents were reported same-day.

Vaccine Adverse Event: A patient developed systemic symptoms 2–3 hours after receiving the Meningococcal B vaccine on 4/22, requiring an ED visit. VAERS was filed same-day. Allergy documentation is pending in the medical record.

Mandated Reporting; A BH therapist filed mandated reports with DCS and FPD on 4/10 following a minor client's disclosure of a sexual relationship with an adult co-worker. Response was timely and fully compliant.

HIPAA / PHI Breach: PHI was sent to an incorrect payer by email on 5/6. Supervisor review was incomplete at the time of reporting. QI review for breach determination is currently in progress.

Staff-as-Patient Policy: 2 incidents this period have prompted the DOO to initiate a formal Staff-as-Patients policy. DOO and QI/C Director will finalize policy and present it to board for review.

Supervisor Review Compliance: Two of 16 incident reports had incomplete supervisor reviews at the time of reporting. Follow-up is in progress. Supervisor accountability remains a standing quality focus.

Glycemic Control — EHR Data Integrity Issue Identified and Corrected: During the Glycemic Control Subcommittee review, it was discovered that the diabetic non-compliant patient list being pulled from the EHR was not accurately reflecting actual patient status. The DOO and HIS staff worked together to identify the root cause and develop a corrective workflow. The fix is in place; however, we will be monitoring it going forward to ensure the workflow is functioning correctly and that our data is reliable before expanding outreach efforts.

Positive Indicators: No medication errors, no patient injuries at the facility, and mandated reporting was executed fully and on time. Provider-level corrective actions were completed within the reporting period.

Patient Safety Indicators

Indicator	This Period	Prior Period
Medication errors	0	0
Patient injuries at facility	0	0
Vaccine adverse events	1	0
Mandated reports filed (DCS / FPD)	1	1
HIPAA / PHI incidents	1	2
Staff injuries	2	0
Patient complaints received	1	1
Patient complaints closed this period	1	1
Incomplete supervisor reviews	2	3

Corrective Actions & Follow-Up

Action Item	Status	Owner
PSC 4-point check — FHC front desk	Ongoing	QI / FHC Leadership
HIPAA breach review — PHI / incorrect payer	Under review	QI Director

VAERS follow-up; allergy documentation	VAERS filed; allergy documentation pending	FHC Nursing / QI
Provider EHR documentation retraining	Completed	DOO / FHC
Staff-as-Patients policy — Board review	In development	DOO / QI Director
Exam room equipment — defective stools	Resolved	FHC / Facilities

Section 4: GPRA Performance Report

Reporting Period: October 1, 2025 – May 6, 2026

Performance Overview

Measures Meeting or Exceeding IHS Target

- **Childhood Weight Control:** 100% — sustained well above the 22% target.
- **Statin Therapy — CVD Risk in Patients with Diabetes:** 100% — sustained well above the 52% target.
- **Diabetes: Blood Pressure Control:** 66.67% — above the 57% target; stable from prior period.
- **Depression Screening Ages 12–17:** 45.83% — above the 36% target; strong upward trajectory.

Notable Improvement Trends (April to May)

- **Diabetic Retinopathy:** 44.93%, up from 40.3% (+4.6 pts) — within 2 points of the 47% IHS target. IHS coding requirements are under review.
- **Diabetes: Nephropathy Assessment:** 36.23%, up from 31.34% (+4.9 pts) — strong movement toward the 44% target.
- **Depression Screening Ages 12–17:** 45.83%, up from 40.3% (+5.5 pts) — now comfortably above target.
- **Depression Screening Age 18+:** 29.72%, up from 26.16% (+3.6 pts) — recovering from October workflow reset; continued outreach recommended.
- **Alcohol Screening:** 32.74%, up from 29.54% (+3.2 pts) — recovering from October reset; not yet at the 36% target.
- **Tobacco Use Assessment (Screening + Use):** Both measures recovering month-over-month; still well below the 50% target — workflow evaluation ongoing.
- **Statin Therapy — CVD Prevention:** 34.07%, up from 32.35% (+1.7 pts) — approaching the 36% target.

Areas Requiring Focused Attention

- **Dental Measures (Access, Sealants, Topical Fluoride):** All remain at 0%. Dental staffing is the primary limiting factor.
- **HIV Screening:** 2.81% against a 42% IHS target. A workflow and standing orders conversation is needed.
- **SBIRT:** 0% — stagnant. A dedicated QI action item is recommended for the next reporting cycle.
- **IPV/DV Exam:** 10.27% against a 30% target. IPV/DV workflow development is in progress.
- **Cancer Screenings (Mammogram, Cervical, Colorectal):** All significantly below IHS targets with no movement April to May.

Full GPRA Performance Table — October 1, 2025 to May 6, 2026

Green shading indicates the measure is at or above the IHS target for the current year.

NACA NATIVE AMERICANS FOR COMMUNITY ACTION

Measure	IHS Target	Prior Year	Current Year (Oct 1, 2025–May 6, 2026)	Trend / Notes
Access to Dental Services	27.0%	0.08%	0%	No change — staffing gap
Adult Immunizations — Pneumococcal Vaccine	39.0%	46.27%	42.86%	Declining; below target
Adult Immunizations — Shingrix	39.0%	30.83%	32.91%	Improving; below target
Adult Immunizations — TDaP	39.0%	28.84%	28.19%	Slight decline
Adult Immunizations Comprehensive	39.0%	25.0%	24.34%	Slight decline
Adult Immunizations TDaP/Td	39.0%	24.91%	24.19%	Slight decline
Adult Influenza Immunization	21.0%	11.35%	6.84%	Season-dependent; expected
Alcohol Screening	36.0%	48.9%	32.74%	Recovering from Oct reset
Cancer Screening: Mammogram Rates	40.0%	32.35%	28.07%	No movement; persistent gap
Cervical Cancer Screening	35.0%	15.14%	13.98%	No movement; persistent gap
Child Influenza Immunization	18.0%	13.0%	8.89%	Season-dependent; expected
Childhood Weight Control	22.0%	100%	100%	Sustained — well above target
Colorectal Cancer Screening	24.0%	9.12%	8.94%	Marginal; below target
Controlling High Blood Pressure (Million Hearts)	48.0%	33.33%	47.22%	Watch: fractionally below target; strong YOY gain
Dental Sealants	11.0%	1.52%	0%	No change — staffing gap
Depression Screening: Age 18+	39.0%	47.27%	29.72%	Recovering from Oct reset
Depression Screening: Ages 12–17	36.0%	57.69%	45.83%	Above target — improving
Diabetes Glycemic Control (A1c <9 — inverse)	12.0%	32.05%	40.58%	Inverse measure — higher = more uncontrolled
Diabetes: Blood Pressure Control	57.0%	66.67%	66.67%	Above target — stable
Diabetes: Nephropathy Assessment	44.0%	28.21%	36.23%	+5 pts; approaching target
Diabetic Retinopathy	47.0%	29.49%	44.93%	+5 pts; near target — strong movement

HIV Screening	42.0%	2.96%	2.81%	Persistent gap — workflow needed
Intimate Partner & Domestic Violence (IPV/DV) Exam	30.0%	12.36%	10.27%	Below target; workflow in progress
SBIRT	15.0%	0.41%	0%	No movement — QI action needed
Statin Therapy — CVD Prevention	36.0%	33.04%	34.07%	Improving; approaching target
Statin Therapy — CVD Risk/Diabetes	52.0%	100%	100%	Sustained — well above target
Tobacco Cessation	27.0%	14.6%	12.41%	Persistent gap — flat
Tobacco Use Assessment: Screening	50.0%	45.02%	30.06%	Recovering from Oct reset; well below target
Tobacco Use Assessment: Tobacco Use	50.0%	40.98%	25.38%	Recovering from Oct reset; well below target
Topical Fluoride	27.0%	0%	0%	No change — staffing gap

Section 5: Quality Studies, SMART Goals & PDSA

Current SMART Goal Status

- **FHC Diabetic Management, A1c <9 (inverse goal 12.5%):** 40.58% — elevated. Active focus under PIP #1 and the Glycemic Control Subcommittee.
- **No-Show Reduction PIP:** Launched May 2026 in collaboration with the DOO. LUMA go-live on May 12, 2026 is the primary action item. Data analysis is ongoing.
- **Retinopathy Exam Completion (goal 44%):** 44.93% — at target. IHS coding requirements are under active review.
- **Controlling High Blood Pressure (Million Hearts):** 47.22% — fractionally below the 48% IHS target; monitoring continues.
- **Annual/Wellness Exam on rolling 12 months (goal 50%):** 12% — no change from prior year. Outreach and scheduling workflow review recommended.
- **Hand Hygiene (goal 85%+):** Monitoring ongoing.

HIM & Technology Updates

- **LUMA Implementation:** Go-live May 12, 2026.
- **NextGen (NG8) Upgrade:** Planned for early 2026.
- Cross-reference mapping and coding with the new Population Health module is underway. GPRA reporting resets October 1.

Performance Improvement Projects (PIPs) 2025–2026

PIP	Quality Activities

NACA
NATIVE AMERICANS FOR COMMUNITY ACTION

PIP #1: Expand chronic disease management programs targeting diseases prevalent in the Native population.	QI Study focused on A1c compliance. Implement Diabetic Education Program. Increase retinopathy exam completion rate. Incorporate peer review into the PIP by implementing diabetic chart reviews.
PIP #2: Reduce the No-Show Rate.	Implement accurate appointment reminder systems. Implement pre-registration and check-in for appointments. Enhance patient education on appointment importance. Collect data on reasons for cancellations, reschedules, and no-shows.
PIP #3: Enhance Safety Compliance and Emergency Program.	Provide education and training to all NACA staff on emergency response, safety, and compliance. Sustain HealthStream training. Investigate and implement additional training opportunities. Facilitate emergency drills.
PIP #4: Utilize GPRA, UDS, and/or other measures to improve patient outcomes.	A1c study as above. Collaborate with external partners to address care gaps by implementing an activity to increase patient completion rate of annual wellness exams. Consider an additional measure based on NACA performance relative to GPRA, UDS, and/or other benchmarking data.
PIP #5: Expand Integrated Care Models.	Develop care coordination initiatives. Use data to close care gaps. Launch cross-sector initiatives.

Next QIC Meeting: May 28, 2026

Section 6: Patient Satisfaction

Patient satisfaction data was collected via voluntary electronic survey across NACA service sites in May 2026 (n=8). This report compares May 2026 results against April 2026 (n=7), March 2026 (n=8), and the 2025 baseline (n=26, May–December 2025). May responses included Family Health Center (n=6) and two responses without a recorded site. Behavioral Health and the Wellness Center had no May submissions.

4.85 May 2026 Overall Avg n=8	**88%** Referral Likelihood (4–5) 7 of 8 respondents	**4.66** 2025 Baseline Avg n=26 | May–Dec 2025	**▲ +0.19** May vs. 2025 Baseline 3rd consecutive month above baseline

Overall Satisfaction Trend

May 2026 overall satisfaction averaged 4.85 out of 5.00 — the third consecutive month above the 2025 baseline of 4.66, and the strongest performance recorded since the high-water mark of March 2026 (4.83). The 2026 trend arc shows a February dip (4.43), a strong March rebound (4.83), a sustained April (4.78), and a May recovery to 4.85. Seven of eight May respondents rated referral likelihood at 4 or 5 (88%); the referral average was 4.38, reflecting one low-scoring outlier that does not signal a systemic concern given the overall pattern.

Domain Score Comparison — All Periods

Color coding reflects May 2026 vs. 2025 baseline: green = improved · amber = within ±0.05 · red = declined.

Domain	2025 Baseline	Mar 2026	Apr 2026	May 2026	Trend vs Baseline
Ease of Getting Care / Access	4.69	4.88	4.29	5.00	▲ +0.31
Hours This Location Is Open	4.54	4.88	4.71	5.00	▲ +0.46
Prompt Return on Calls	4.46	4.75	4.43	5.00	▲ +0.54
Time in Waiting Room	4.50	4.88	4.57	5.00	▲ +0.50

Domain	2025 Baseline	Mar 2026	Apr 2026	May 2026	Trend vs Baseline
Time in Exam Room	4.35	4.75	4.71	4.62	▲ +0.27
Waiting for Tests	4.31	4.75	4.71	4.88	▲ +0.57
Listens to You	4.85	5.00	4.86	4.50	▼ -0.35
Takes Enough Time with You	4.69	5.00	4.86	4.50	▼ -0.19
Explains What You Want to Know	4.85	5.00	5.00	4.50	▼ -0.35
Gives Good Advice and Treatment	4.88	5.00	5.00	4.50	▼ -0.38
Input into Care Decisions (Provider)	4.81	5.00	4.86	5.00	▲ +0.19
Friendly and Answers Qs (Provider)	4.81	4.88	5.00	5.00	▲ +0.19
Input into Care Decisions (Staff)	4.81	4.88	4.86	5.00	▲ +0.19
Friendly and Answers Qs (Staff)	4.85	4.25	5.00	4.75	▼ -0.10
Cost / Billing Fairness	4.27	4.25	4.86	4.71	▲ +0.44
Neat and Clean Building	4.73	4.88	4.71	5.00	▲ +0.27
Ease of Finding Where to Go	4.69	5.00	4.71	5.00	▲ +0.31
Comfort and Safety While Waiting	4.73	4.88	4.71	5.00	▲ +0.27
Privacy and Confidentiality	4.69	4.88	4.86	5.00	▲ +0.31
Culture and Traditions Respected	4.65	4.88	4.86	5.00	▲ +0.35
OVERALL AVERAGE	**4.66**	**4.83**	**4.78**	**4.85**	**▲ +0.19**

Key Insights — May 2026

Strengths

- Access and logistics domains — Ease of Getting Care, Hours Open, Prompt Return on Calls, Time in Waiting Room — all scored a perfect 5.00 in May, a significant rebound from April's access dip (4.29) that had been the main concern last cycle.
- Staff engagement domains — Input into Care Decisions, Friendly and Answers Questions (both Provider and Staff levels), Neat and Clean Building, Ease of Finding Where to Go, Comfort and Safety, Privacy, and Culture and Traditions — all scored 5.00 or 4.75+.
- Cost / Billing Fairness held at 4.71 — well above the long-standing 4.27 baseline, suggesting April's billing improvement (4.86) was not a single-month anomaly.

Areas to Monitor

- Clinical interaction domains — Listens to You, Takes Enough Time, Explains What You Want to Know, and Gives Good Advice — all scored 4.50 in May, down from 5.00 in both March and April. This appears tied to FHC site mix and the paper survey cohort; not a clinical quality concern at this sample size, but worth tracking.
- Referral likelihood dropped to 4.38 / 88% — down from 100% in March and April. One respondent rated referral at 1, which drove the average down. Given NACA's otherwise strong scores this month, this does not indicate a systemic trust issue but will be monitored.

- Patient comments flagged provider turnover and front desk responsiveness (“Turnover” as a concern). Multiple respondents requested Saturday hours (9–2). These themes are consistent with prior months and relevant to PIP #2 and #5.

Health Literacy — May 2026

Baseline health literacy data was not collected systematically in 2025; comparisons cover Feb–May 2026 only.

Literacy Measure	Feb 2026	Mar 2026	Apr 2026	May 2026
Understands Medical Home Concept	44%	63%	43%	50%
Emergency Care Awareness	89%	88%	100%	100%
Urgent Care Awareness	89%	88%	100%	100%
Knows How to Get Medical Records	67%	75%	86%	100%
Knows Provider Availability	67%	75%	57%	100%

Health Literacy Observations

- Emergency and urgent care awareness: 100% in May — returned to and held at full marks for the second consecutive month after dipping in Feb–Mar.
- Medical records access awareness: 100% in May — the highest recorded, recovering strongly from 86% in April and 75% in March.
- Provider availability awareness: 100% in May — a major rebound from April’s concerning drop to 57%.
- Medical home understanding: 50% — improved from April’s low of 43%, but still the lowest health literacy measure across all periods. Embedding medical home language into appointment reminders and the rooming workflow remains a standing recommendation.

May 2026 reflects a strong and broad-based recovery across access, logistics, and literacy domains — areas of concern in prior months. Clinical interaction scores warrant ongoing monitoring given the FHC-heavy respondent mix. The third consecutive month above the 2025 baseline signals sustained improvement rather than a point-in-time anomaly. Continued BH and Wellness Center survey collection is a standing quality priority.

Section 7: Peer Review

Peer-to-Peer evaluations for medical staff were completed in May 2026 and will be formally reported to the Board at the June meeting. Chart reviews are currently being assigned through the Medical Executive Committee (MEC) process and are expected to be completed within the next 30 days.

Section 8: Emergency Management & Safety

Safety Plan & Facility Overview

- **Safety Plan:** Reviewed last month and approved by the Board of Directors.
- **Facility Fire Inspection:** Due June 2026.

Facility Drills

- **Snow Delay (January 9, 2026):** Real event; documented as an operational drill.
- **Next Scheduled Drill:** Medical Emergency — due April–June 2026.
- **Emergency App:** Not utilized in the past month.

Monthly Hazard Surveillance Rounds — April 22, 2026

NACA
NATIVE AMERICANS
FOR COMMUNITY ACTION

Sites surveyed: Family Health Clinic (FHC), Behavioral Health (BH), Wellness Center, Medical Records, and GSA/Admin. Surveyor: Francisco Rendon, QI & Compliance Director.

Fire extinguishers were current and tags updated at all locations. The majority of clinical areas were organized and in good order. Findings were documented in the follow-up tracking log and assigned to responsible parties.

Total Findings	Deficiencies (Open)	Near Compliance (Open)
33 items logged	11 open	22 open

Family Health Clinic

- Expired gloves in lab (exp. 3/30/2026); sharps container near capacity — pickup required.
- Eyewash station sticker ripped; station expires September 2026 — sticker replacement and expiration monitoring needed.
- Multiple ADA restroom deficiencies pending Facilities correction (dispenser heights, toilet handles, plumbing covers).
- Refrigerator remains elevated on 2x4s — permanent placement solution needed.
- Cast cutter found unsecured in utility area.
- Kitchen and break area housekeeping: fridge cleaning log needed; microwave and trash can require attention.
- HP cubicle area being used as storage due to space constraints — department lead coordination needed.
- Rights and responsibilities signage is outdated; staff photo display needs updating.

Behavioral Health

- Wall chipping and holes in lobby area require patching and repainting.
- Boxes stored in IT room — not a designated storage area; IT team notification needed.
- Ladder found unsecured in hallway — needs designated storage location.
- Refrigerator condensation noted at back; trash can is dirty.

Wellness Center

- Lobby light fixture cover needs cleaning; one floor tile has shifted out of place.
- Office lighting dim or flickering in some areas — bulb evaluation by Facilities needed.
- TRX A-frame remains unbolted per IHS safety recommendation — contractor action pending.

Medical Records

- Ventilation cover dirty; refrigerator needs wipe-down.
- Front desk computer needs privacy screens — IT request to be submitted.
- Cracked board/panel with escutcheon visible — repair or replacement needed.
- Exit sign annual inspection due July 2026 — schedule in advance.

GSA / Admin

- Electrical panel in back room inaccessible — key missing. Panel must remain accessible per life-safety standards.
- Storage room needs shelving and reorganization; old finance records (2007–2008) to be reviewed for retention or disposal.
- Minimum wage poster on breakroom bulletin board may be outdated for Flagstaff — HR verification needed.
- IT room AC unit rust stain and dusty vent require cleaning.
- Dining area fridge and ice maker lack cleaning logs and designated ownership.

April 2026 Improvements Completed

ID	Building / Area	Resolution	Closed
—	FHC – Electrical Panels	Electrician reviewed and correctly labeled all previously unlabeled breakers.	Apr 2026
—	FHC – Doors	Badge access installed on clinic doors for compliant and convenient access.	Apr 2026
—	FHC – Door Hardware	Two door deficiencies repaired: loose handle tightened; severely squeaking door corrected.	Apr 2026
—	FHC – Lobby Lighting	Lobby lights converted to LED; expected to reduce energy costs and extend bulb lifespan.	Apr 2026
60	FHC – Back Door	Back door latch repaired — no longer sticks or requires rattling to close.	Apr 2026
76	GSA – Back Door	Back door looseness repaired by Facilities.	Apr 2026
78	GSA – Front Common Area	Unclaimed personal item removed from common area.	Apr 2026

Next Steps — Facilities & Safety

- Next monthly hazard surveillance rounds due: May 2026.
- Facility Fire Inspection due: June 2026.
- Exit sign annual inspection to be scheduled before July 2026.
- Eyewash station expiration to be monitored — renewal due September 2026.
- Quarterly Facility Inspections: schedule for April–June 2026 quarter.
- Follow up with Facilities on ADA restroom corrections across FHC and GSA.
- HR to verify minimum wage poster compliance for Flagstaff.
- Contractor to be engaged for TRX A-frame bolting at Wellness Center.
- IT request to be submitted for Medical Records privacy screens.

Training & Community Plan

- **Upcoming / Ongoing Training:** Fire Extinguisher Training, De-escalation, Detailed HIPAA, Stop the Bleed.

Section 9: Committees & Workgroups

Active Committees

- **QIC:** Ongoing. Next meeting: May 28, 2026.
- **Emergency Management & Safety:** Ongoing.
- **Medical Executive Committee (MEC):** Ongoing.
- **Directors / Leadership:** Ongoing.
- **Infection Control Committee:** Ongoing.
- **All-Clinic Staff Meetings:** Ongoing.
- **AAAHC Workgroup:** On hold.
- **Glycemic Control Subcommittee:** Active — see Section 10.

Section 10: Glycemic Control Subcommittee Update

The Glycemic Control Subcommittee continues focused work on improving diabetic compliance, outreach workflows, care gap closure, and GPRA diabetic performance measures. Current efforts remain aligned with NACA's Performance Improvement Project (PIP) on chronic disease management and integrated care coordination. Previous Board reporting has demonstrated improvement in diabetic compliance measures, including movement in diabetic retinopathy completion and glycemic control metrics.

Current Focus Areas

- Validation of the diabetic non-compliant patient list.
- Outreach workflow standardization.
- Care coordination challenges involving patients receiving services across multiple clinics.
- Coding and documentation consistency for diabetic quality measures.
- Transportation and patient engagement barriers.
- Workflow preparation for LUMA implementation and patient communication improvements.

Infection Control Assessment and Response (ICAR) Tool for General Infection Prevention and Control (IPC) Across Settings

Section 1: Facility Demographics and Infection Prevention and Control (IPC) Infrastructure
Outpatient/Ambulatory Care

General Facility Demographics and IPC Infrastructure

Date of Assessment: ___________

Facility Name: ____

State/Territory: _____________________________ **County:** _____________________________

Zip Code: ___________ **State/Territory-assigned Unique ID** (if applicable): _________________

Facility type (Complete the demographic form that corresponds to the type of facility):

- Acute Care Hospital / Critical Access Hospital
- Long-term Care
- Outpatient/Ambulatory Care
- Other *(specify)*: ____

NHSN Facility Organization ID (if applicable): _________________

CMS Facility ID (if applicable): _________________

Facility Respondent Name(s) and Job Title(s):

Rationale for assessment:

- Requested by facility
- Requested by accrediting agency/ licensing organization
- Requested by state or local health department
- HAI prevention focused:
  - CAUTI
  - CLABSI
  - SSI
  - CDI
  - Other *(specify)*: ____
- Prevention collaborative (specify partners): ____
- Outbreak *(specify)*: ____
- Other *(specify)*: ____

Obtain a list of products used for cleaning and disinfection of environmental surfaces and non-critical patient/resident care equipment in the facility

EPA registration number(s) for products used in patient/resident rooms:

____

EPA registration number(s) for products used in common areas:

____

EPA registration number(s) for products used on non-critical patient/resident care equipment (e.g., blood glucose meters):

____

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CS334433-N 11/29/2022

1. Does the facility have access to **onsite** IPC expertise?

Yes
No
Unknown
Not Assessed

If YES, specify:

Healthcare epidemiologist (number of full-time equivalents **dedicated** to IPC activities):

Infection preventionist (number of full-time equivalents **dedicated** to IPC activities):

Other (specify, including number of full-time equivalents **dedicated** to IPC activities):

Note: This is intended to identify individuals who work onsite at the facility or provide IP oversight at satellite locations (e.g., hospital IP provides IP oversight to affiliated outpatient clinics) and what proportion of their time is dedicated to IPC activities. Example: The facility has two IPs. IP #1 spends 25% of their time on IPC activities and the rest of their time on direct patient care and IP #2 spends 75% of their time on IPC activities and the rest of the time on direct patient care. This would be recorded as IP: 1 FTE dedicated to IPC activities. This breakdown could be further described in the notes.

2. Does the facility have access to **offsite** IPC expertise?

Yes
No
Unknown
Not Assessed

If YES, specify:

Healthcare epidemiologist (number of full-time equivalents dedicated to IPC activities **at the facility**):

Infection preventionist (number of full-time equivalents dedicated to IPC activities **at the facility**):

Other (specify, including number of full-time equivalents dedicated to IPC activities **at the facility**):

Note: This is intended to identify individuals who do not work primarily onsite at the facility but might provide IPC support on a contractual or part-time basis. If a full-time equivalent cannot be determined, the level of support should be described in the notes.

3. Does the person(s) charged with directing the IPC program at the facility hold a nationally recognized credential in infection control (e.g., a-IPC, CIC, LTC-CIP, BCIDP)?

Yes
No
Unknown
Not Assessed

Lack of certification does not mean that an individual is not qualified to direct the IPC program. **Describe their qualification(s) (e.g., other certifications, specialized training):**

4. What additional duties are performed by personnel within the IPC program? *(select all that apply)*

- Occupational Health
- Education of personnel
- Safety officer
- Administrative (e.g., Director of Nursing)
- None
- Not assessed
- Other *(specify)*: ____________________

5. What does the director of the IPC program believe are the current strengths and weaknesses in the IPC program?

6. Does the IPC program have access to electronic medical records of patients/residents?

- Yes
- No
- Unknown
- Not Assessed

7. Does the IPC program utilize data mining/reporting software?

- Yes
- No
- Unknown
- Not Assessed

8. Does the IPC program perform an annual facility infection risk assessment that evaluates and prioritizes potential risks for infections, contamination, and exposures and the program's preparedness to eliminate or mitigate such risks?

- Yes
- No
- Unknown
- Not Assessed

9. Are written infection control policies and procedures available, current, and based on evidence-based guidelines (e.g., CDC/HICPAC), regulations, or standards?

- Yes
- No
- Unknown
- Not Assessed

9a. How frequently are policies and procedures reviewed and updated? *(select all that apply)*

- Annually
- Every three years
- As needed when new guidelines or evidence is published (e.g., via subscription with a publisher)
- Unknown
- Not assessed
- Other *(specify)*: ____________________

Note: Facilities should have a schedule to regularly review policies and procedures to ensure they are current. At a minimum, updates should be made when new evidence-based guidance is published and if the scope of care delivered changes (e.g., new equipment is introduced or new procedures are performed).

10. Does the IPC program provide infection prevention education to patients, family members, and other caregivers?

- Yes
- No
- Unknown
- Not Assessed

If YES:

10a. What topics are covered? *(specify)*

10b. How is this education provided (e.g., information included in the admission or discharge packet, videos, signage, in-person training)? *(specify)*

11. Does the facility have an interdisciplinary infection control committee to address issues identified by the IPC program?

- Yes
- No
- Unknown
- Not Assessed

Note: Issues identified by the IPC program often impact multiple areas of the facility. An interdisciplinary committee, including facility leadership (e.g., ownership, chief medical officer, director of nursing), is needed to allocate resources and successfully implement long-term solutions.

If YES, specify:

11a. Who is part of the infection control committee? *(select all that apply)*

- Chief Medical Officer
- Director of Nursing
- Environmental Services
- Unknown
- Not Assessed
- Other *(specify)*: ____________________

11b. How often does the infection control committee meet?

- Monthly
- Quarterly
- Unknown
- Not Assessed
- Other *(specify)*: ____________________

Notes

Facility Demographics: Outpatient/Ambulatory Care

1. Is the facility licensed by the state?

Yes
No

2. Is the facility certified by the Centers for Medicare & Medicaid Services (CMS)?

Yes, as an Ambulatory Surgical Center
Yes, as a Federally Qualified Health Center
Yes, as another provider type (*specify*): ______________________________
No

3. Is the facility accredited?

Yes
No

If YES, specify:

3a. The accreditation organization:

Accreditation Association for Ambulatory Health Care (AAAHC)
American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
American Osteopathic Association (AOA)
The Joint Commission (TJC)
Other (*specify*): ______________________________

3b. Date of last survey (month/year):__________

4. Is the facility part of a hospital system?

Yes
No

5. Which procedures are performed by the facility? (*select all that apply*)

Chemotherapy
Dermatology
Endoscopy
Imaging
Immunizations
OB/Gyn
Ophthalmologic
Orthopedic
Pain remediation
Plastic/reconstructive
Podiatry
Surgery (general)
Urology
Other (specify):______________________________

6. How many physicians work at the facility? __________

7. What is the average number of patients seen per day? __________

Notes

Appendix B. Tuberculosis (TB) risk assessment worksheet

This model worksheet should be considered for use in performing TB risk assessments for health-care facilities and nontraditional facility-based settings. Facilities with more than one type of setting will need to apply this table to each setting.

Scoring √ or Y = Yes	**X or N = No**	**NA = Not Applicable**

1. Incidence of TB

What is the incidence of TB in your community (county or region served by the health-care setting), and how does it compare with the state and national average? What is the incidence of TB in your facility and specific settings and how do those rates compare? (Incidence is the number of TB cases in your community the previous year. A rate of TB cases per 100,000 persons should be obtained for comparison.)* This information can be obtained from the state or local health department.	Community rate 0.67 State rate 2.8 National rate 3.1 Facility rate 0 Department 1 rate _______ Department 2 rate _______ Department 3 rate _______
Are patients with suspected or confirmed TB disease encountered in your setting (inpatient and outpatient)?	**Yes** (circled) No
If yes, how many patients with suspected and confirmed TB disease are treated in your health-care setting in 1 year (inpatient and outpatient)? Review laboratory data, infection-control records, and databases containing discharge diagnoses.	Year No. patients Suspected Confirmed 1 year ago _____ _____ 2 years ago _____ _____ 5 years ago _____ _____
If no, does your health-care setting have a plan for the triage of patients with suspected or confirmed TB disease?	**Yes** (circled) No
Currently, does your health-care setting have a cluster of persons with confirmed TB disease that might be a result of ongoing transmission of *Mycobacterium tuberculosis* within your setting (inpatient and outpatient)?	Yes **No** (circled)

2. Risk Classification

Inpatient settings	
How many inpatient beds are in your inpatient setting?	
How many patients with TB disease are encountered in the inpatient setting in 1 year? Review laboratory data, infection-control records, and databases containing discharge diagnoses.	Previous year ______ 5 years ago ______
Depending on the number of beds and TB patients encountered in 1 year, what is the risk classification for your inpatient setting? (See Appendix C.)	o Low risk o Medium risk o Potential ongoing transmission
Does your health-care setting have a plan for the triage of patients with suspected or confirmed TB disease?	Yes No
Outpatient settings	
How many TB patients are evaluated at your outpatient setting in 1 year? Review laboratory data, infection-control records, and databases containing discharge diagnoses.	Previous year 0 5 years ago 0
Is your health-care setting a TB clinic? (If yes, a classification of at least medium risk is recommended.)	Yes **No** (circled)
Does evidence exist that a high incidence of TB disease has been observed in the community that the health-care setting serves?	Yes **No** (circled)
Does evidence exist of person-to-person transmission of *M. tuberculosis* in the health-care setting? (Use information from case reports. Determine if any tuberculin skin test [TST] or blood assay for *M. tuberculosis* [BAMT] conversions have occurred among health-care workers [HCWs]).	Yes **No** (circled)
Does evidence exist that ongoing or unresolved health-care–associated	Yes **No** (circled)

transmission has occurred in the health-care setting (based on case reports)?	
Is there a high incidence of immunocompromised patients or HCWs in the health-care setting?	Yes **No** (circled)
Have patients with drug-resistant TB disease been encountered in your health-care setting within the previous 5 years?	Yes **No** (circled) Year ________
When was the first time a risk classification was done for your health-care setting?	4.2025
Considering the items above, would your health-care setting need a higher risk classification?	Yes **No** (circled)
Depending on the number of TB patients evaluated in 1 year, what is the risk classification for your outpatient setting? (See Appendix C)	o Low risk (circled) o Medium risk o Potential ongoing transmission
Does your health-care setting have a plan for the triage of patients with suspected or confirmed TB disease?	**Yes** (circled) No
Nontraditional facility-based settings	
How many TB patients are encountered at your setting in 1 year?	Previous year ______ 5 years ago ______
Does evidence exist that a high incidence of TB disease has been observed in the community that the setting serves?	Yes No
Does evidence exist of person-to-person transmission of *M. tuberculosis* in the setting?	Yes No
Have any recent TST or BAMT conversions occurred among staff or clients?	Yes No
Is there a high incidence of immunocompromised patients or HCWs in the setting?	Yes No
Have patients with drug-resistant TB disease been encountered in your health-care setting within the previous 5 years?	Yes No Year ________
When was the first time a risk classification was done for your setting?	
Considering the items above, would your setting require a higher risk classification?	Yes No
Does your setting have a plan for the triage of patients with suspected or confirmed TB disease?	Yes No
Depending on the number of patients with TB disease who are encountered in a nontraditional setting in 1 year, what is the risk classification for your setting? (See Appendix C)	o Low risk o Medium risk o Potential ongoing transmission

3. Screening of HCWs for *M. tuberculosis* Infection

Does the health-care setting have a TB screening program for HCWs?	**Yes** (circled) No
If yes, which HCWs are included in the TB screening program? (Check all that apply.) o Physicians X o Mid-level practitioners (nurse practitioners [NP] and physician's assistants [PA]) X o Nurses X o Administrators X o Laboratory workers o Respiratory therapists	o Janitorial staff X o Maintenance or engineering staff X o Transportation staff o Dietary staff o Receptionists X o Trainees and students X o Volunteers X o Others_________________

o Physical therapists o Contract staff o Construction or renovation workers X o Service workers X	
Is baseline skin testing performed with two-step TST for HCWs?	Yes No
Is baseline testing performed with QFT or other BAMT for HCWs?	Yes No
How frequently are HCWs tested for *M. tuberculosis* infection?	at hire
Are the *M. tuberculosis* infection test records maintained for HCWs?	Yes No
Where are the *M. tuberculosis* infection test records for HCWs maintained? Who maintains the records?	Employee Health Records by ICC
If the setting has a serial TB screening program for HCWs to test for *M. tuberculosis* infection, what are the conversion rates for the previous years? † 1 year ago 0 4 years ago 0 2 years ago 0 5 years ago 0 3 years ago 0	
Has the test conversion rate for *M. tuberculosis* infection been increasing or decreasing, or has it remained the same over the previous 5 years? (check one)	o Increasing o Decreasing o No change
Do any areas of the health-care setting (e.g., waiting rooms or clinics) or any group of HCWs (e.g., lab workers, emergency department staff, respiratory therapists, and HCWs who attend bronchoscopies) have a test conversion rate for *M. tuberculosis* infection that exceeds the health-care setting's annual average?	Yes No If yes, list ______
For HCWs who have positive test results for *M. tuberculosis* infection and who leave employment at the health setting, are efforts made to communicate test results and recommend follow-up of latent TB infection (LTBI) treatment with the local health department or their primary physician?	Yes No Not applicable

4. TB Infection-Control Program

Does the health-care setting have a written TB infection-control plan?	Yes No
Who is responsible for the infection-control program?	Infection Control Committee
When was the TB infection-control plan first written?	2024
When was the TB infection-control plan last reviewed or updated?	2024, annually
Does the written infection-control plan need to be updated based on the timing of the previous update (i.e., >1 year, changing TB epidemiology of the community or setting, the occurrence of a TB outbreak, change in state or local TB policy, or other factors related to a change in risk for transmission of *M. tuberculosis*)?	Yes No
Does the health-care setting have an infection-control committee (or another committee with infection control responsibilities)?	Yes No
If yes, which groups are represented on the infection-control committee? (Check all that apply.) o Physicians X o Nurses X o Epidemiologists o Engineers o Pharmacists	o Laboratory personnel o Health and safety staff X o Administrator X o Risk assessment X o Quality control (QC) X o Others (specify)______

If no, what committee is responsible for infection control in the setting?	

5. Implementation of TB Infection-Control Plan Based on Review by Infection-Control Committee

Has a person been designated to be responsible for implementing an infection-control plan in your health-care setting? If yes, list the name: ___	[circled] Yes No
Based on a review of the medical records, what is the average number of days for the following: • Presentation of patient until collection of specimen 3 • Specimen collection until receipt by laboratory 2 • Receipt of specimen by laboratory until smear results are provided to health-care provider 2-5 • Diagnosis until initiation of standard antituberculosis treatment 1 • Receipt of specimen by laboratory until culture results are provided to health-care provider 5-14 • Receipt of specimen by laboratory until drug-susceptibility results are provided to health-care provider 5-14 • Receipt of drug-susceptibility results until adjustment of antituberculosis treatment, if indicated 5-14 • Admission of patient to hospital until placement in airborne infection isolation (AII) ___	
Through what means (e.g., review of TST or BAMT conversion rates, patient medical records, and time analysis) are lapses in infection control recognized?	
What mechanisms are in place to correct lapses in infection control?	
Based on measurement in routine QC exercises, is the infection-control plan being properly implemented?	[circled] Yes No
Is ongoing training and education regarding TB infection-control practices provided for HCWs?	[circled] Yes No

6. Laboratory Processing of TB-Related Specimens, Tests, and Results Based on Laboratory Review

Which of the following tests are either conducted in-house at your health-care setting's laboratory or sent out to a reference laboratory?	In-house	Sent out
Acid-fast bacilli (AFB) smears		X
Culture using liquid media (e.g., Bactec and MB-BacT)		X
Culture using solid media		X
Drug-susceptibility testing		X
Nucleic acid amplification (NAA) testing		X
What is the usual transport time for specimens to reach the laboratory for the following tests? AFB smears 1 Culture using liquid media (e.g., Bactec, MB-BacT) 1 Culture using solid media 1 Drug-susceptibility testing 1 Other (specify) ___ NAA testing 1		
Does the laboratory at your health-care setting or the reference laboratory used by your health-care setting report AFB smear results for all patients within 24 hours of receipt of specimen? What is the procedure for weekends?	[circled] Yes No ___ ___	

7. Environmental Controls

Which environmental controls are in place in your health-care setting? (Check all that apply and describe) <u>Environmental control</u> <u>Description</u> X AII rooms ___

o Local exhaust ventilation (enclosing devices and exterior devices) ____________ X General ventilation (e.g., single-pass system, recirculation system.) ____________ X Air-cleaning methods (e.g., high-efficiency particulate air [HEPA] filtration and ultraviolet germicidal irradiation [UVGI]) ____________	
What are the actual air changes per hour (ACH) and design for various rooms in the setting? Room ACH Design ____________ ____________ ____________ ____________ ____________	
Which of the following local exterior or enclosing devices such as exhaust ventilation devices are used in your health-care setting? (Check all that apply) o Laboratory hoods o Booths for sputum induction o Tents or hoods for enclosing patient or procedure	
What general ventilation systems are used in your health-care setting? (Check all that apply) X Single-pass system o Variable air volume (VAV) o Constant air volume (CAV) o Recirculation system o Other____________	
What air-cleaning methods are used in your health-care setting? (Check all that apply) HEPA filtration X Fixed room-air recirculation systems o Portable room-air recirculation systems UVGI o Duct irradiation o Upper-air irradiation o Portable room-air cleaners	
How many AII rooms are in the health-care setting?	
What ventilation methods are used for AII rooms? (Check all that apply) Primary (general ventilation): X Single-pass heating, ventilating, and air conditioning (HVAC) o Recirculating HVAC systems Secondary (methods to increase equivalent ACH): o Fixed room recirculating units X HEPA filtration o UVGI o Other (specify) ____________	
Does your health-care setting employ, have access to, or collaborate with an environmental engineer (e.g., professional engineer) or other professional with appropriate expertise (e.g., certified industrial hygienist) for consultation on design specifications, installation, maintenance, and evaluation of environmental controls?	**[Yes]** No
Are environmental controls regularly checked and maintained with results recorded in maintenance logs?	Yes **[No]**
Are AII rooms checked daily for negative pressure when in use?	Yes **[No]**
Is the directional airflow in AII rooms checked daily when in use with smoke tubes or visual checks?	Yes **[No]**

Are these results readily available?		Yes **No** (circled)
What procedures are in place if the AII room pressure is not negative?	______	
Do AII rooms meet the recommended pressure differential of 0.01-inch water column negative to surrounding structures?		**Yes** (circled) No

8. Respiratory-Protection Program

Does your health-care setting have a written respiratory-protection program?	**Yes** (circled) No

Which HCWs are included in the respiratory protection program? (Check all that apply)

- o Physicians X
- o Mid-level practitioners (NPs and PAs) X
- o Nurses X
- o Administrators X
- o Laboratory personnel
- o Contract staff X
- o Construction or renovation staff X
- o Service personnel X
- o Janitorial staff X
- o Maintenance or engineering staff
- o Transportation staff
- o Dietary staff
- o Students X
- o Others (specify)______

Are respirators used in this setting for HCWs working with TB patients? If yes, include manufacturer, model, and specific application (e.g., ABC model 1234 for bronchoscopy and DEF model 5678 for routine contact with infectious TB patients).

Manufacturer	Model	Specific application

Is annual respiratory-protection training for HCWs performed by a person with advanced training in respiratory protection?	Yes **No** (circled)
Does your health-care setting provide initial fit testing for HCWs? If yes, when is it conducted? ______	**Yes** (circled) No
Does your health-care setting provide periodic fit testing for HCWs? If yes, when and how frequently is it conducted? ______	**Yes** (circled) No
What method of fit testing is used? Describe.	
Is qualitative fit testing used?	**Yes** (circled) No
Is quantitative fit testing used?	Yes **No** (circled)

9. Reassessment of TB risk

How frequently is the TB risk assessment conducted or updated in the health-care setting?	Annual
When was the last TB risk assessment conducted?	

What problems were identified during the previous TB risk assessment?

1) N/A
2) ______
3) ______

4) ______
5) ______
What actions were taken to address the problems identified during the previous TB risk assessment? 1) N/A 2) ______ 3) ______ 4) ______ 5) ______

Did the risk classification need to be revised as a result of the last TB risk assessment?	Yes No (No circled)

* If the population served by the health-care facility is not representative of the community in which the facility is located, an alternate comparison population might be appropriate.

† Test conversion rate is calculated by dividing the number of conversions among HCWs by the number of HCWs who were tested and had prior negative results during a certain period (see Supplement, Surveillance and Detection of *M. tuberculosis* infections in Health-Care Settings).

GUIDE TO INFECTION PREVENTION FOR OUTPATIENT SETTINGS:

MINIMUM EXPECTATIONS FOR SAFE CARE

FILLABLE FORM

National Center for Emerging and Zoonotic Infectious Diseases

Division of Healthcare Quality Promotion

Version 2.3 - September 2016

How to Use This Document

This guide has been created to help you evaluate Infection Prevention at your facility.

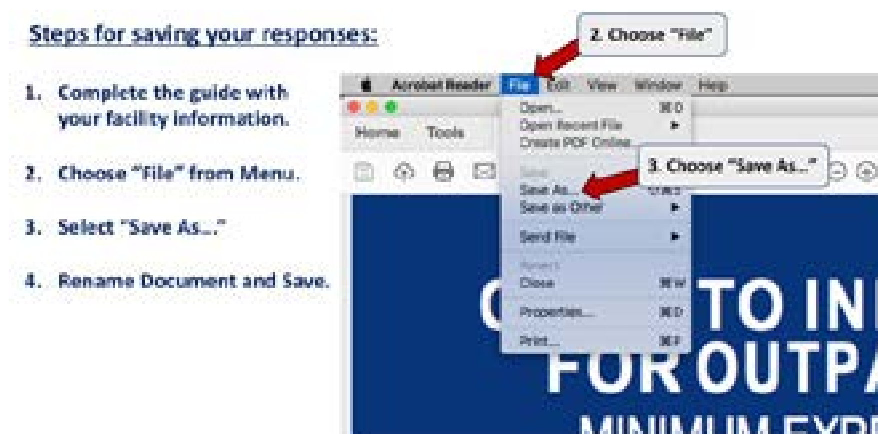
It is an interactive PDF document that is best viewed with Adobe Acrobat Reader.

To get the latest version of Adobe Acrobat Reader, please visit: https://get.adobe.com/reader/

This Interactive PDF will let you perform an evaluation by answering questions, creating notes, and pasting text content into this document.

Once you have completed your responses, save the document with a different file name to create a new and current version of the guide.

The steps to save the new guide copy are below:



This interactive document also includes hyperlinks to enable you to mark sections that do not apply to you and skip ahead to the next section by clicking on a link in the document.

We hope you find this to be a useful resource for your organization.

APPENDIX A: INFECTION PREVENTION CHECKLIST FOR OUTPATIENT SETTINGS

This checklist is a companion to the Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care and is intended to assist in the assessment of infection control programs and practices in outpatient settings. The checklist should be used:

1. To ensure that the facility has appropriate infection prevention policies and procedures in place and supplies to allow healthcare personnel (HCP) to provide safe care.

2. To systematically assess personnel adherence to correct infection prevention practices. In order to complete the assessment, direct observation of infection control practices will be necessary.

Providers using this checklist should identify all procedures performed in their facility and refer to appropriate sections to conduct their evaluation. Certain sections may not apply (e.g., some settings may not perform sterilization or high-level disinfection). If the answer to any of the listed questions is No, efforts should be made to correct the practice, appropriately educate HCP (if applicable), and determine why the correct practice was not being performed. Consideration should also be made for determining the risk posed to patients by the deficient practice. Certain infection control lapses (e.g., re-use of syringes on more than one patient or to access a medication container that is used for subsequent patients; re-use of lancets) have resulted in bloodborne pathogen transmission and should be halted immediately. Identification of such lapses warrants immediate consultation with the state or local health department and appropriate notification and testing of potentially affected patients.

Overview

Section 1: Facility Demographics
Section 2: Infection Control Program and Infrastructure
Section 3: Direct Observation of Facility Practices
Section 4: Infection Control Guidelines and Other Resources

Infection Control Domains for Gap Assessment

I: Infection Control Program and Infrastructure

II: Infection Control Training and Competency

III. Healthcare Personnel Safety

IV. Surveillance and Disease Reporting

V.a/b. Hand Hygiene

VI.a/b. Personal Protective Equipment (PPE)

VII.a/b. Injection Safety (if applicable)

VIII.a/b. Respiratory Hygiene/Cough Etiquette

IX.a/b. Point-of-Care Testing (if applicable)

X.a/b. Environmental Cleaning

XI.a/b. Device Reprocessing

XII. Sterilization of Reusable Devices (if applicable)

XIII. High-Level Disinfection of Reusable Devices (if applicable)

Section 1: Facility Demographics
Facility Name: ____

Questions	Details
Is the facility licensed by the state?	Yes No Other If yes, Date of last inspection: ____________ Were any infection control deficiencies identified during the last inspection? Yes No Other If Yes, ensure those elements are evaluated during the assessment.
Is the facility certified by the Centers for Medicare & Medicaid Services (CMS)?	Yes No Other If yes, Date of last inspection: ____________ Were any infection control deficiencies identified during the last inspection? Yes No Other If Yes, ensure those elements are evaluated during the assessment.
Is the facility accredited?	Yes No Other If yes, list the accreditation organization: Accreditation Association for Ambulatory Health Care (AAAHC) American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) American Osteopathic Association (AOA) The Joint Commission (TJC) Other (specify): Other (specify): Other (specify): Date of last inspection: ____________ Were any infection control deficiencies identified during the last inspection? Yes No Other If Yes, ensure those elements are evaluated during the assessment.
Is the facility affiliated with a hospital?	Yes No If Yes, consider engaging with the hospital infection prevention program for assistance in remediation of any identified lapses.
Which procedures are performed by the facility? Select all that apply.	Chemotherapy Imaging (MRI/CT) Ophthalmologic Plastic/reconstructive Endoscopy Immunizations Orthopedic Podiatry Ear/Nose/Throat PB/Gyn Pain remediation Other: ____________________ Other: ____________________ Other: ____________________ Other: ____________________ Other: ____________________ Other: ____________________

Section 2: Infection Control Program and Infrastructure

I: Infection Control Program and Infrastructure

Elements to be assessed	Assessment	Notes/Areas for Improvement
A. Written infection prevention policies and procedures are available, current, and based on evidence-based guidelines (e.g., CDC/ HICPAC), regulations, or standards. *Note: Policies and procedures should be appropriate for the services provided by the facility and should extend beyond OSHA bloodborne pathogens training* **Please paste the link to your policies & procedures below:** ____	Yes No Other	
B. Infection prevention policies and procedures are reassessed at least annually or according to state or federal requirements, and updated if appropriate.	Yes No Other	
C. At least one individual trained in infection prevention is employed by or regularly available (e.g., by contract) to manage the facility's infection control program. *Note: Examples of training may include: Successful completion of initial and/or recertification exams developed by the Certification Board for Infection Control & Epidemiology; participation in infection control courses organized by the state or recognized professional societies (e.g., APIC, SHEA).*	Yes No Other	
D. Facility has system for early detection and management of potentially infectious persons at initial points of patient encounter. *Note: System may include taking a travel and occupational history, as appropriate, and elements described under respiratory hygiene/cough etiquette.*	Yes No Other	

Comments:

II: Infection Control Program and Infrastructure

Elements to be assessed	Assessment	Notes/Areas for Improvement
A. Facility has a competency-based training program that provides job-specific training on infection prevention policies and procedures to healthcare personnel. *Note: This includes those employed by outside agencies and available by contract or on a volunteer basis to the facility.* *See sections below for more specific assessment of training related to: hand hygiene, personal protective equipment (PPE), injection safety, environmental cleaning, point-of-care testing, and device reprocessing.*	Yes No Other	

Comments:

III. Healthcare Personnel Safety

Elements to be assessed	Assessment	Notes/Areas for Improvement
A. Facility has an exposure control plan that is tailored to the specific requirements of the facility (e.g., addresses potential hazards posed by specific services provided by the facility). *Note: A model template, which includes a guide for creatingan exposure control plan that meets the requirements of the OSHA Bloodborne Pathogens Standard is available at:* https://www.osha.gov/Publications/osha3186.pdf	Yes No Other	
B. HCP for whom contact with blood or other potentially infectious material is anticipated are trained on the OSHA bloodborne pathogens standard upon hire and at least annually.	Yes No Other	
C. Following an exposure event, post-exposure evaluation and follow-up, including prophylaxis as appropriate, are available at no cost to employee and are supervised by a licensed healthcare professional. *Note: An exposure incident refers to a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an individual's duties*	Yes No Other	
D. Facility tracks HCP exposure events and evaluates event data and develops/implements corrective action plans to reduce incidence of such events.	Yes No Other	
E. Facility follows recommendations of the Advisory Committee on Immunization Practices (ACIP) for immunization of HCP, including offering Hepatitis B and influenza vaccination. *Note: Immunization of Health-Care Personnel: Recommendations of the ACIP available at:* http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6007a1.htm	Yes No Other	
F. All HCP receive baseline tuberculosis (TB) screening prior to placement; HCP receive repeat testing, if appropriate, based upon the facility-level risk assessment and/or state regulations. *Note: Please Contact your* **State TB Control Program** *for information about health care worker TB testing requirements in your state.* *Note: For more information, facilities should refer to the Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005 available at:* **https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm?s_cid-rr5417al_c**	Yes No Other	
G. If respirators are used, the facility has a respiratory protection program that details required worksite-specific procedures and elements for required respirator use, including provision of medical clearance, training, and fit testing as appropriate.	Yes No Other	

III: Healthcare Personnel Safety *(continued)*

Elements to be assessed	Assessment	Notes/Areas for Improvement
H. Facility has well-defined policies concerning contact of personnel with patients when personnel have potentially transmissible conditions. These policies include: i. Work-exclusion policies that encourage reporting of illnesses and do not penalize with loss of wages, benefits, or job status. ii. Education of personnel on prompt reporting of illness to supervisor. **Please paste the link to your policies & procedures below:** ______________________________________	Yes No Other	

Comments:

IV. Surveillance and Disease Reporting

Elements to be assessed	Assessment	Notes/Areas for Improvement
A. An updated list of diseases reportable to the public health authority is readily available to all personnel.	Yes No Other	
B. Facility can demonstrate knowledge of and compliance with mandatory reporting requirements for notifiable diseases, healthcare associated infections (as appropriate), and for potential outbreaks.	Yes No Other	
C. Patients who have undergone procedures at the facility are educated regarding signs and symptoms of infection that may be associated with the procedure and instructed to notify the facility if such signs or symptoms occur.	Yes No Other	

Comments:

V.a. Hand Hygiene

Elements to be assessed	Assessment	Notes/Areas for Improvement
A. All HCP are educated regarding appropriate indications for hand hygiene: i. Upon hire, prior to provision of care ii. Annually	Yes No Other Yes No Other	
B. HCP are required to demonstrate competency with hand hygiene following each training.	Yes No Other	
C. Facility routinely audits (monitors and documents) adherence to hand hygiene.	Yes No Other	
D. Facility provides feedback from audits to personnel regarding their hand hygiene performance.	Yes No Other	
E. Hand hygiene policies promote preferential use of alcohol-based hand rub over soap and water in most clinical situations. *Note: Soap and water should be used when hands are visibly soiled (e.g. blood, body fluids) and is also preferred after caring for a patient with known or suspected C. difficile or norovirus during an outbreak.*	Yes No Other	

Comments:

VI.a. Personal Protective Equipment (PPE)

Elements to be assessed	Assessment	Notes/Areas for Improvement
A. HCP who use PPE receive training on proper selection and use of PPE: i. Upon hire, prior to provision of care ii. Annually iii. When new equipment or protocols are introduced	Yes No Other Yes No Other Yes No Other	
B. HCP are required to demonstrate competency with selection and use of PPE following each training.	Yes No Other	
C. Facility routinely audits (monitors and documents) adherence to proper PPE selection and use. Observational Tool Link - CDC iCar	Yes No Other	
D. Facility provides feedback from audits to personnel regarding their performance with selection and use of PPE.	Yes No Other	

Comments:

VII.a. Injection Safety (This element does not include assessment of pharmacy/ compounding practices)

If injectable medications are never prepared or administered at the facility check

Not Applicable here and skip to **Section VIII.a. Respiratory Hygiene/Cough Etiquette.**

Elements to be assessed	Assessment	Notes/Areas for Improvement
A. HCP who prepare and/or administer parenteral medications receive training on safe injection practices: i. Upon hire, prior to being allowed to prepare and/or administer parenteral medications ii. Annually iii. When new equipment or protocols are introduced	 Yes No Other Yes No Other Yes No Other	
B. HCP are required to demonstrate competency with safe injection practices following each training.	Yes No Other	
C. Facility routinely audits (monitors and documents) adherence to safe injection practices.	Yes No Other	
D. Facility provides feedback from audits to personnel regarding their adherence to safe injection practices.	Yes No Other	
E. Facility has policies and procedures to track HCP access to controlled substances to prevent narcotics theft/diversion. *Note: Policies and procedures should address: how data are reviewed, how facility would respond to unusual access patterns, how facility would assess risk to patients if tampering (alteration or substitution) is suspected or identified, and who the facility would contact if diversion is suspected or identified.*	Yes No Not applicable *(Facility does not prepare or administer controlled substances)*	

Comments:

VIII.a. Respiratory Hygiene/Cough Etiquette

Elements to be assessed	Assessment	Notes/Areas for Improvement
A. Facility has policies and procedures to contain respiratory secretions in persons who have signs and symptoms of a respiratory infection, beginning at point of entry to the facility and continuing through the duration of the visit. Policies include:	Yes No Other	
i. Offering facemasks to coughing patients and other symptomatic persons upon entry to the facility, at a minimum, during periods of increased respiratory infection activity in the community.	Yes No Other	
ii. Providing space in waiting rooms and encouraging persons with symptoms of respiratory infections to sit as far away from others as possible. *Note: If available, facilities may wish to place patients with symptoms of a respiratory infection in a separate area while waiting for care.*	Yes No Other	
B. Facility educates HCP on the importance of infection prevention measures to contain respiratory secretions to prevent the spread of respiratory pathogens.	Yes No Other	

IX.a. Point-of-Care Testing (e.g., blood glucose meters, INR monitor)

If point-of-care testing is never performed at the facility check

Not Applicable here and skip to **Section X.a. Environmental Cleaning****.**

Elements to be assessed	Assessment	Notes/Areas for Improvement
A. HCP who perform point-of-care testing receive training on recommended practices:		
i. Upon hire, prior to being allowed to perform point-of-care testing	Yes No Other	
ii. Annually	Yes No Other	
iii. When new equipment or protocols are introduced	Yes No Other	
B. HCP are required to demonstrate competency with recommended practices for point-of-care testing following each training.	Yes No Other	
C. Facility routinely audits (monitors and documents) adherence to recommended practices during point-of-care testing.	Yes No Other	
D. Facility provides feedback from audits to personnel regarding their adherence to recommended practices.	Yes No Other	

X.a. Environmental Cleaning

Elements to be assessed	Assessment	Notes/Areas for Improvement
A. Facility has written policies and procedures for routine cleaning and disinfection of environmental surfaces, including identification of responsible personnel.	Yes No Other	
B. Personnel who clean and disinfect patient care areas (e.g., environmental services, technicians, nurses) receive training on cleaning procedures:		
i. Upon hire, prior to being allowed to perform environmental cleaning	Yes No Other	
ii Annually	Yes No Other	
iii. When new equipment or protocols are introduced *Note: If environmental cleaning is performed by contract personnel, facility should verify this is provided by contracting company.*	Yes No Other	
C. HCP are required to demonstrate competency with environmental cleaning procedures following each training.	Yes No Other	
D. Facility routinely audits (monitors and documents) adherence to cleaning and disinfection procedures, including using products in accordance with manufacturer's instructions (e.g., dilution, storage, shelf-life, contact time).	Yes No Other	
E. Facility provides feedback from audits to personnel regarding their adherence to cleaning and disinfection procedures.	Yes No Other	
F. Facility has a policy/procedure for decontamination of spills of blood or other body fluids.	Yes No Other	

Comments:

X.a. Environmental Cleaning *(continued)* - Operating room

For the purposes of this checklist, an operating room is defined as a patient care area that met the Facilities Guidelines Institute's (FGI) or American Institute of Architects' (AIA) criteria for an operating room when it was constructed or renovated. This is the same definition that is used in the National Healthcare Safety Network's Procedure-associated Module for the SSI Event (http://www.cdc.gov/nhsn/pdfs/pscmanual/9pscssicurrent.pdf)

If the facility does not have an operating room check **Not Applicable** here and skip to section XI.a. Device Reprocessing below.

Elements to be assessed	Assessment	Notes/Areas for Improvement
G. Operating rooms are terminally cleaned after last procedure of the day.	Yes No Other	
H. Facility routinely audits (monitors and documents) adherence to recommended infection control practices for surgical infection prevention including: i. Adherence to preoperative surgical scrub and hand hygiene ii. Appropriate use of surgical attire and drapes iii. Adherence to aseptic technique and sterile field iv. Proper ventilation requirements in surgical suites v. Minimization of traffic in the operating room vi. Adherence to cleaning and disinfection of environmental surfaces	Yes No Other Yes No Other Yes No Other Yes No Other Yes No Other Yes No Other	
I. Facility provides feedback from audits to personnel regarding their adherence to surgical infection prevention practices	Yes No Other	

XI.a. Device Reprocessing

The following basic information allows for a general assessment of policies and procedures related to reprocessing of reusable medical devices. Outpatient facilities that are performing on-site sterilization or high-level disinfection of reusable medical devices should refer to the more detailed checklists in separate sections of this document devoted to those issues.

Categories of Medical Devices:

- **Critical items** (e.g., surgical instruments) are objects that enter sterile tissue or the vascular system and must be sterile prior to use (see Sterilization Section).
- **Semi-critical items** (e.g., endoscopes for upper endoscopy and colonoscopy, vaginal probes) are objects that contact mucous membranes or non-intact skin and require, at a minimum, high-level disinfection prior to reuse (see High-level Disinfection Section).
- **Non-critical items** (e.g., blood pressure cuffs) are objects that may come in contact with intact skin but not mucous membranes and should undergo cleaning and low- or intermediate-level disinfection depending on the nature and degree of contamination.

XI.a. Device Reprocessing (continued)

Single-use devices (SUDs) are labeled by the manufacturer for a single use and do not have reprocessing instructions. They may not be reprocessed for reuse except by entities which have complied with FDA regulatory requirements and have received FDA clearance to reprocess specific SUDs.
Note: Cleaning must always be performed prior to sterilization and disinfection

Elements to be assessed	Assessment	Notes/Areas for Improvement
A. Facility has policies and procedures to ensure that reusable medical devices are cleaned and reprocessed appropriate prior to use on another patient. *Note: This includes clear delineation of responsibility among HCP for cleaning and disinfection of equipment including, non-critical equipment, mobile devices, and other electronics (e.g., point-of-care devices) that might not be reprocessed in a centralized reprocessing area.*	Yes No Other	
B. The individual(s) in charge of infection prevention at the facility is consulted whenever new devices or products will be purchased or introduced to ensure implementation of appropriate reprocessing policies and procedures.	Yes No Other	
C. HCP responsible for reprocessing reusable medical devices receive hands-on training on proper selection and use of PPE and recommended steps for reprocessing assigned devices: i. Upon hire, prior to being allowed to reprocess devices ii. Annually iii. When new devices are introduced or policies/procedures change. *Note: If device reprocessing is performed by contract personnel, facility should verify this is provided by contracting company.*	Yes No Other Yes No Other Yes No Other	
D. HCP are required to demonstrate competency with reprocessing procedures (i.e., correct technique is observed by trainer) following each training.	Yes No Other	
E. Facility routinely audits (monitors and documents) adherence to reprocessing procedures.	Yes No Other	
F. Facility provides feedback from audits to personnel regarding their adherence to reprocessing procedures.	Yes No Other	
G. Facility has protocols to ensure that HCP can readily identify devices that have been properly reprocessed and are ready for patient use (e.g., tagging system, storage in designated area).	Yes No Other	

Comments:

Elements to be assessed	Assessment	Notes/Areas for Improvement
H. Facility has policies and procedures outlining facility response (i.e., risk assessment and recall of device) in the event of a reprocessing error or failure.	Yes No Other	
I. Routine maintenance for reprocessing equipment (e.g., automated endoscope reprocessors, steam autoclave) is performed by qualified personnel in accordance with manufaturer instructions; confirm maintenance records are available.	Yes No Other Not Applicable *(Reprocessing equipment is not used at the facility*	

Section 3: Direct Observation of Facility Practices   As of (Date): ____________

V.b. Hand Hygiene

Elements to be assessed	Assessment	Notes/Areas for Improvement
A. Supplies necessary for adherence to hand hygiene (e.g., soap, water, paper towels, alcohol-based hand rub) are readily accessible to HCP in patient care areas.	Yes No Other	
Hand hygiene is performed correctly:		
B. Before contact with the patient	Yes No Other	
C. Before performing an aseptic task (e.g., insertion of IV or preparing an injection, administering eye drops)	Yes No Other Not Applicable	
D. After contact with the patient	Yes No Other	
E. After contact with objects in the immediate vicinity of the patient	Yes No Other	
F. After contact with blood, body fluids or contaminated surfaces	Yes No Other	
G. After removing gloves	Yes No Other	
H. When moving from a contaminated-body site to a clean-body site during patient care	Yes No Other Not Applicable	

VI.b. Personal Protective Equipment

Elements to be assessed	Assessment	Notes/Areas for Improvement
A. Sufficient and appropriate PPE is available and readily accessible to HCP.	Yes No Other	
PPE is used correctly:		
B. PPE, other than respirator, is removed and discarded prior to leaving the patient's room or care area. If a respirator i used, it is removed and discarded (or reprocessed if reusable) after leaving the patient room or care area and closing the door.	Yes No Other	
C. Hand hygiene is performed immediately after removal of PPE.	Yes No Other	
D. Gloves i. HCP wear gloves for potential contact with blood, body fluids, mucous membranes, non-intact skin, or contaminated equipment. ii. HCP **<u>do not</u>** wear the same pair of gloves for the care of more than one patient. iii. HCP **<u>do not</u>** wash gloves for the purpose of reuse.	Yes No Other Yes No Other Yes No Other	
E. Gowns i. HCP wear gowns to protect skin and clothing during procedures or activities where contact with blood or body fluids is anticipated. ii. HCP **<u>do not</u>** wear the gown for the care of more than one patient.	Yes No Other Not Applicable Yes No Other Not Applicable	
F. Facial Protection i. HCP wear mouth, nose, and eye protection during procedures that are likely to generate splashes or sprays of blood or other body fluids.	Yes No Other Not Applicable	

Comments:

VII.b. Injection safety (This element does not include assessment of pharmacy compounding practices)

If injectable medications are never prepared or administered at the facility check Not Applicable here and skip to **Section VIII.b. Respiratory Hygiene/Cough Etiquette.**

Elements to be assessed	Assessment	Notes/Areas for Improvement
A. Injections are prepared using aseptic technique in a clean area free from contamination or contact with blood, body fluids or contaminated equipment.	Yes No Other	
B. Needles and syringes are used for only one patient (this includes manufactured prefilled syringes and cartridge devices such as insulin pens).	Yes No Other	
C. The rubber septum on a medication vial is disinfected with alcohol prior to piercing.	Yes No Other	
D. Medication containers are entered with a new needle and a new syringe, even when obtaining additional doses for the same patient.	Yes No Other	
E. Single dose (single-use) medication vials, ampules, and bags or bottles of intravenous solution are used for only one patient.	Yes No Other	
F. Medication administration tubing and connectors are used for only one patient.	Yes No Other N/A *(Facility does not use tubing or connectors.)*	
G. Multi-dose vials are dated by HCP when they are first opened and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial.	Yes No Other N/A *(Facility does not use multi-dose vials or discards them after single patient use)*	
H. Multi-dose vials to be used for more than one patient are kept in a centralized medication area and do not enter the immediate patient treatment area (e.g., operating room, patient room/cubicle).	Yes No Other N/A *(Facility does not use multi-dose vials or discards them after single patient use)*	
I. All sharps are disposed of in a puncture-resistant sharps container.	Yes No Other	

VII.b. Injection safety (This element does not include assessment of pharmacy/compounding practices) *(continued)*

Elements to be assessed	Assessment	Notes/Areas for Improvement
J. Filled sharps containers are disposed of in accordance with state regulated medical waste rules	Yes No Other	
K. All controlled substances (e.g., Schedule II, III, IV, V drugs) are kept locked within a secure area.	Yes No Other N/A *(Controlled substances are not kept at the facility)*	
L. HCP wear a facemask (e.g., surgical mask) when placing a catheter or injecting material into the epidural or subdural space (e.g., during myelogram, epidural or spinal anesthesia).	Yes No Other N/A *(Facility does not perform spinal injection procedures)*	

Comments:

VIII.b. Respiratory Hygiene/Cough Etiquette

Elements to be assessed	Assessment	Notes/Areas for Improvement
A. Facility i. Posts signs at entrances with instructions to patients with symptoms of respiratory infection to: a. Inform HCP of symptoms of a respiratory infection when they first register for care, and b. Practice Respiratory Hygiene/Cough Etiquette (cover their mouths/noses when coughing or sneezing, use and dispose of tissues, and perform hand hygiene after hands have been covered with respiratory secretions).	Yes No Other	
ii. Provides tissues and no-touch receptacles for disposal of tissues.	Yes No Other	
iii. Provides resources for performing hand hygiene in or near waiting areas	Yes No Other	

Comments:

IX.b. Point-of-Care Testing (e.g., blood glucose meters, INR monitor)

If point-of-care testing is never performed at the facility check Not Applicable here and skip to Section X.b. Environmental Cleaning below.

Elements to be assessed	Assessment	Notes/Areas for Improvement
A. New single-use, auto-disabling lancing device is used for each patient. *Note: Lancet holder devices are not suitable for multi-patient use.*	Yes No Other N/A	
B. If used for more than one patient, the point-of-care blood testing meter is cleaned and disinfected after every use according to manufacturer's instructions. *Note: If the manufacturer does not provide instructions for cleaning and disinfection, then the testing meter should not be used for >1 patient.*	Yes No Other N/A	

Comments:

X.b. Environmental Cleaning

Elements to be assessed	Assessment	Notes/Areas for Improvement
A. Supplies necessary for appropriate cleaning and disinfection procedures (e.g., EPA-registered disinfectants) are available. *Note: If environmental services are performed by contract personnel, facility should verify that appropriate EPA-registered products are provided by contracting company*	Yes No Other	
B. High-touch surfaces in rooms where surgical or other invasive procedures (e.g., endoscopy, spinal injections) are performed are cleaned and then disinfected with an EPA-registered disinfectant after each procedure.	Yes No Other N/A	
C. Cleaners and disinfectants are used in accordance with manufacturer's instructions (e.g., dilution, storage, shelf-life, contact time).	Yes No Other	
D. HCP engaged in environmental cleaning wear appropriate PPE to prevent exposure to infectious agents or chemicals (PPE can include gloves, gowns, masks, and eye protection). *Note: The exact type of correct PPE depends on infectious or chemical agent and anticipated type of exposure.*	Yes No Other	

XI.b. Device Reprocessing

Elements to be assessed	Assessment	Notes/Areas for Improvement
A. Policies, procedures, and manufacturer reprocessing instructions for reusable medical devices used in the facility are available in the reprocessing area(s).	Yes No Other	
B. Reusable medical devices are cleaned, reprocessed (disinfection or sterilization) and maintained according to the manufacturer instructions. *Note: If the manufacturer does not provide such instructions, the device may not be suitable for multi-patient use.*	Yes No Other	
C. Single-use devices are discarded after use and not used for more than one patient unless they have been appropriately reprocessed as described in the note below. *Note: If the facility elects to reuse single-use devices, these devices must be reprocessed prior to reuse by a third-partyreprocessor that it is registered with the FDA as a third-party reprocessor and cleared by the FDA to reprocess the specific device in question. The facility should have documentation fromthe third party reprocessor confirming this is the case.*	Yes No Other	
D. Reprocessing area: i. Adequate space is allotted for reprocessing activities. ii. A workflow pattern is followed such that devices clearly flow from high contamination areas to clean/sterile areas (i.e., there is clear separation between soiled and clean workspaces).	Yes No Other	
E. Adequate time for reprocessing is allowed to ensure adherence to all steps recommended by the device manufacturer, including drying and proper storage. *Note: Facilities should have an adequate supply of instruments for the volume of procedures performed and should schedule procedures to allow sufficient time for all reprocessing steps*	Yes No Other	
F. HCP engaged in device reprocessing wear appropriate PPE to prevent exposure to infectious agents or chemicals (PPE can include gloves, gowns, masks, and eye protection). *Note: The exact type of correct PPE depends on infectious or chemical agent and anticipated type of exposure.*	Yes No Other	
G. Medical devices are stored in a manner to protect from damage and contamination.	Yes No Other	

Comments:

XII. Sterilization of Reusable Devices

If all device sterilization is performed off-site, complete elements M-O below and check for the remaining elements in this section. Not Applicable

If sterilization of reusable devices is never performed (either at the facility or off-site) check here and skip to Section XIII. Not Applicable

Elements to be assessed	Assessment	Notes/Areas for Improvement
A. Devices are thoroughly cleaned according to manufacturer instructions and visually inspected for residual soil prior to sterilization. *Note: Cleaning may be manual (i.e., using friction) and/or mechanical (e.g., with ultrasonic cleaners, washer-disinfector, washer-sterilizers). Ensure appropriately sized cleaning brushes are selected for cleaning device channels and lumens.*	Yes No Other N/A	
B. Cleaning is performed as soon as practical after use (e.g., at the point of use) to prevent soiled materials from becoming dried onto devices.	Yes No Other N/A	
C. Enzymatic cleaner or detergent is used for cleaning and discarded according to manufacturer's instructions (typically after each use).	Yes No Other N/A	
D. Cleaning brushes are disposable or, if reusable, cleaned and high-level disinfected or sterilized (per manufacturer's instructions) after use.	Yes No Other N/A	
E. After cleaning, instruments are appropriately wrapped/packaged for sterilization (e.g., package system selected is compatible with the sterilization process being performed, items are placed correctly into the basket, shelf or cart of the sterilizer so as not to impede the penetration of the sterilant, hinged instruments are open, instruments are disassembled if indicated by the manufacturer).	Yes No Other N/A	
F. A chemical indicator (process indicator) is placed correctly in the instrument packs in every load.	Yes No Other N/A	
G. A biological indicator, intended specifically for the type and cycle parameters of the sterilizer, is used at least weekly for each sterilizer and with every load containing implantable items.	Yes No Other N/A	

Comments:

XII. Sterilization of Reusable Devices *(continued)*

Elements to be assessed	Assessment	Notes/Areas for Improvement
H. For dynamic air removal-type sterilizers (e.g., prevacuusteam sterilizer), an air removal test (Bowie-Dick test) is performed in an empty dynamic-air removal sterilizer each day the terilizer is used to verify efficacy of air removal.	Yes No Other N/A	
I. Sterile packs are labeled with a load number that indicates the sterilizer used, the cycle or load number, the date of sterilization, and, if applicable, the expiration date	Yes No Other N/A	
J. Sterilization logs are current and include results from each load.	Yes No Other N/A	
K. Immediate-use steam sterilization, if performed, is only done in circumstances in which routine sterilization procedures cannot be performed	Yes No Other N/A	
L. Instruments that undergo immediate-use steam sterilization are used immediately and not stored.	Yes No Other N/A	
M. After sterilization, medical devices are stored so that sterility is not compromised.	Yes No Other N/A	
N. Sterile packages are inspected for integrity and compromised packages are reprocessed prior to use.	Yes No Other N/A	
O. The facility has a process to perform initial cleaning of devices (to prevent soiled materials from becoming dried onto devices) prior to transport to the off-site reprocessing facility.	Yes No Other N/A	

XIII. High-Level Disinfection of Reusable Devices

If all high-level disinfection is performed off-site, complete elements L-N below and check Not Applicable **for the remaining elements in this section.**

If high-level disinfection of reusable devices is never performed (either at the facility or off-site) check

Not Applicable **here.**

Elements to be assessed	Assessment	Notes/Areas for Improvement
A. Flexible endoscopes are inspected for damage and leak tested as part of each reprocessing cycle. Any device that fails the leak test is removed from clinical use and repaired.	Yes No Other N/A	

XIII. High-Level Disinfection of Reusable Devices *(continued)*

Elements to be assessed	Assessment	Notes/Areas for Improvement
B. Devices are thoroughly cleaned according to manufacturer instructions and visually inspected for residual soil prior to high-level disinfection. *Note: Cleaning may be manual (i.e., using friction) and/or mechanical (e.g., with ultrasonic cleaners, washer-disinfector, washer-sterilizers). Ensure appropriately sized cleaning brushes are selected for cleaning device channels and lumens.*	Yes No Other N/A	
C. Cleaning is performed as soon as practical after use (e.g., at the point of use) to prevent soiled materials from becoming dried onto instruments.	Yes No Other N/A	
D. Enzymatic cleaner or detergent is used and discarded according to manufacturer instructions (typically after each use).	Yes No Other N/A	
E. Cleaning brushes are disposable or, if reusable, cleaned and high-level disinfected or sterilized (per manufacturer instructions) after use.	Yes No Other N/A	
F. For chemicals used in high-level disinfection, manufacturer instructions are followed for: i. Preparation ii. Testing for appropriate concentration, and iii. Replacement(i.e., upon expiration or loss of efficacy)	Yes No Other N/A	
G. If automated reprocessing equipment (e.g. automated endoscope reprocessor) is used, proper connectors are used to assure that channels and lumens are appropriately disinfected	Yes No Other N/A	
H. Devices are disinfected for the appropriate length of time as specified by manufacturer instructions	Yes No Other N/A	
I. Devices are disinfected at the appropriate temperature as specified by manufacturer instructions.	Yes No Other N/A	
J. After high-level disinfection, devices are appropriately rinsed as specified by the manufacturer.	Yes No Other N/A	

Comments:

XIII. High-Level Disinfection of Reusable Devices *(continued)*

Elements to be assessed	Assessment	Notes/Areas for Improvement
K. Devices are dried thoroughly prior to reuse. *Note: For lumened instruments (e.g., endoscopes) ths includes flushing all channels with alcohol and forcing air through channels.*	Yes No Other N/A	
L. After high-level disinfection, devices are stored in a manner to protect from damage or contamination. *Note: Endoscopes should be hung in a vertical position.*	Yes No Other N/A	
M. Facility maintains a log for each endoscopy procedure which includes: patient's name and medical record number (if available), procedure, date, endoscopist, system used to reprocess the endoscope (if more than one system could be used in the reprocessing area), and serial number or other identifier of the endoscope used	Yes No Other N/A	
N. The facility has a process to perform initial cleaning of devices (to prevent soiled materials from becoming dried onto devices) prior to transport to the off-site reprocessing facility.	Yes No Other N/A	

Section 4: Infection Control Guidelines and Other Resources

• General Infection Prevention

CDC/HICPAC Guidelines and recommendations:
http://www.cdc.gov/HAI/prevent/prevent_pubs.html

• Healthcare Personnel Safety

Guideline for Infection Control in Healthcare Personnel:
http://www.cdc.gov/hicpac/pdf/InfectControl98.pdf

Immunization of HealthCare Personnel:
https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6007a1.htm

Occupational Safety & Health Administration (OSHA) Bloodborne Pathogens and Needlestick Prevention Standard:
https://www.osha.gov/SLTC/bloodbornepathogens/index.html

OSHA Respiratory Protection Standard:
https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=12716&p_table=STANDARDS

OSHA Respirator Fit Testing:
https://www.osha.gov/video/respiratory_protection/fittesting_transcript.html

- **Hand Hygiene**

  Guideline for Hand Hygiene in Healthcare Settings:
  http://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf

  Hand Hygiene in Healthcare Settings:
  https://www.cdc.gov/handhygiene/

  Examples of tools that can be used to conduct a formal audit of hand hygiene practices:
  – http://www.jointcommission.org/assets/1/18/hh_monograph.pdf
  – iScrub APP

- **Personal Protective Equipment**

  2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings: http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

  Guidance for the Selection and Use of Personal Protective Equipment in Healthcare Settings:
  https://www.cdc.gov/HAI/prevent/ppe.html

- **Injection Safety**

  2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings: http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

  CDC Injection Safety Web Materials:
  http://www.cdc.gov/injectionsafety/

  CDC training video and related Safe Injection Practices Campaign materials:
  http://www.oneandonlycampaign.org/

- **Respiratory Hygiene/Cough Etiquette**

  2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings: https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

  Recommendations for preventing the spread of influenza:
  http://www.cdc.gov/flu/professionals/infectioncontrol/

- **Environmental Cleaning**

  Guidelines for Environmental Infection Control in Healthcare Facilities:
  http://www.cdc.gov/hicpac/pdf/guidelines/eic_in_HCF_03.pdf

  Options for Evaluating Environmental Infection Control:
  http://www.cdc.gov/HAI/toolkits/Evaluating-Environmental-Cleaning.html

- **Equipment Reprocessing**

  Guideline for Disinfection and Sterilization in Healthcare Facilities:
  http://www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf

  FDA regulations on reprocessing of single-use devices:
  https://www.fda.gov/downloads/medicaldevices/deviceregulationandguidance/guidancedocuments/ucm253010

- ## Point-of-Care Testing

Infection Prevention during Blood Glucose Monitoring and Insulin Administration:
http://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html

Frequently Asked Questions (FAQs) regarding Assisted Blood Glucose Monitoring and Insulin Administration: http://www.cdc.gov/injectionsafety/providers/blood-glucose-monitoring_faqs.html

- ## Resources to assist with evaluation and response to breaches in infection control

Patel PR, Srinivasan A, Perz JF. Developing a broader approach to management of infection control breaches in health care settings. Am J Infect Control. 2008 Dec; 36(10); 685-90

Steps for Evaluating an Infection Control Breach:
https://www.cdc.gov/hai/outbreaks/steps_for_eval_IC_breach.html

Patient Notification Toolkit:
http://www.cdc.gov/injectionsafety/pntoolkit/index.html

- ## Antibiotic Stewardship

Get Smart Programs & Observances:
http://www.cdc.gov/getsmart/

Notes Page

Please type any notes you would like to retain in this document below.
Don't forget to "Save As..." when done.

Family Heath Center Board Report
May 2026
Prepared by: Verity Quiroz, Director of Operations

Major Highlights:

- AACHC Annual Conference 2026
- NCUIH Annual Conference 2026
- Luma Go-Live May 12, 2026
- Collaboration with QI on No Show PIP Launch May 2026
- MMIPW Event May 5, 2026
- Coconino County Crisis System meeting May 4, 2026
- Referrals for HRSN workflow created in NG
- Ruth, FNP seeing patients!
- Banner PT Meet n Greet May 6, 2026
- Outpatient coder position pending
- Demonstration by XpertDox

Major Challenges:

- Provider stability and reliability
- Workload / Balance
- Limited uninterrupted time to work due to Meeting volume (DOO 55 meetings = 70-85 hours/month)
- New provider payor credentialing & timeline
- Population Health appears inaccurate (working on data validation and NG support) however it is improving
- Chaotic work environment (many changes, moving pieces in short periods of time)
- Billing/Coding on claims for quality measure compliance
- Numerous IRs with front desk

Updates

- Flagstaff Surgical Associates Gastroenterology closed
- Pathfinder ACO closed

Staffing updates:

- Dr Nelson formal offer, anticipate start mid-July 2026
- Resume Physician Recruitment Summer 2026

GPRA: Oct 1, 2025- May 6, 2026

NACA

Family Heath Center Board Report
May 2026
Prepared by: Verity Quiroz, Director of Operations

Metric	IHS Target	Previous Year	Current Year
Access to Dental Services GPRA 2025	27.0%	0.08%	0%
Adult Immunizations - Pneumococcal Vaccine GPRA 2025	39.0%	46.27%	42.86%
Adult Immunizations - Shingrix GPRA 2025	39.0%	30.83%	32.91%
Adult Immunizations - TDaP GPRA 2025	39.0%	29.07%	28.19%
Adult Immunizations Comprehensive GPRA 2025	39.0%	25.21%	24.34%
Adult Immunizations TDaP/Td GPRA 2025	39.0%	25.13%	24.19%
Adult Influenza Immunization GPRA 2025	21.0%	11.5%	6.84%
Alcohol Screening GPRA 2025	36.0%	47.46%	32.74%
Cancer Screening: Mammogram Rates GPRA 2025	40.0%	32.35%	28.07%
	35.0%	15.28%	13.98%
Child Influenza Immunization GPRA 2025	18.0%	13%	8.89%
Childhood Weight Control GPRA 2025	22.0%	100%	100%
Colorectal Cancer Screening GPRA 2025	24.0%	9.14%	8.94%
Controlling High Blood Pressure (Million Hearts) GPRA 2025	48.0%	33.62%	47.22%
Dental Sealants GPRA 2025	11.0%	1.52%	0%
Depression Screening: Age 18 yrs and older GPRA 2025	39.0%	47.59%	29.72%
Depression Screening: Ages 12-17 yrs GPRA 2025	36.0%	57.69%	45.83%
Diabetes Glycemic Control GPRA 2025	12.0%	32.05%	40.58%
Diabetes: Blood Pressure Control GPRA 2025	57.0%	65.38%	66.67%
Diabetes: Nephropathy Assessment GPRA 2025	44.0%	28.21%	36.23%
Diabetic Retinopathy GPRA 2025	47.0%	29.49%	44.93%
HIV Screening GPRA 2025	42.0%	2.98%	2.81%
Intimate Partner & Domestic Violence (IPV/DV) Exam GPRA 2025	30.0%	12.47%	10.27%
Screening, Brief Intervention, and Referral to Treatment (SBIRT) GPRA 2025	15.0%	0.42%	0%
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease GPRA 2025	36.0%	33.04%	34.07%
Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes GPRA 2025	52.0%	100%	100%
Tobacco Cessation GPRA 2025	27.0%	14.6%	12.41%
Tobacco Use and Exposure Assessment: Screening GPRA 2025	50.0%	45.31%	30.06%

Family Heath Center Board Report
May 2026
Prepared by: Verity Quiroz, Director of Operations

Tobacco Use and Exposure Assessment: Tobacco Use GPRA 2025	50.0%	41.25%	25.38%
Topical Fluoride GPRA 2025	27.0%	0%	0%

Infection Control:
- Offering Flu vaccines to all staff and patients through Apr 2026
- Microorganism Report (see attached)
- Measles Awareness

Employee Health:
- Offering Flu Vaccines to all staff free of charge through Apr 2026

Staff Trainings:
- Upcoming: HIPAA Procedures (pending QI Coordination)
- Upcoming: Stop the Bleed (pending QI Coordination)

Annual Policy Updates:
- January: Medical Records & Health Information Management
- February: Health Promotions
- April: Medication Management
- May: Laboratory Services & Infection Control, Infection Control Plan Program
- June: Medical Services

Ongoing Projects:
- P&P generation, revision, deletion – per AAAHC standards
- IHS Site review corrective action plan / Remediation
- Assist with LUMA implementation
- Assist with NG 8 Upgrade
- Implement DM II and HTN protocols with standing orders
- Medical Billing Coding Workgroup
- TempDev completing chart audits, customer satisfaction surveys, custom HPI for DM and HTN templates, 340B report, CKD report, and CHW custom template

2026 Pending Projects/Plans/Goals
- PCMH QI Study
- No Shows Performance Improvement
- Close Referrals / Open Orders - QI Study/Performance Improvement

Family Heath Center Board Report
May 2026
Prepared by: Verity Quiroz, Director of Operations

Committee/Meeting Involvement:

- May 4: Luma Weekly Call
- May 4: Coconino County Crisis call Q2
- May 4: Luma Mtg with Alika and Shay
- May 4: SMPR Planning Mtg
- May 4: QICD/DOO Mtg
- May 4: XpertDox Demo/Intro Mtg
- May 5: MMIP
- May 5: CHW Template with TempDev
- May 5: Pop Health with NG
- May 5: Luma chat f/u with Alika, Linda, Shay, Walt
- May 5: Internal Coding Review Workgroup Mtg
- May 5: IPV/DV Workflow with Kyte
- May 6: CEO-DOO 1:1
- May 6: Interview Fitness Specialist
- May 6: Interview Fitness Specialist
- May 6: Interview Fitness Specialist
- May 6 Meet N Greet Banner PT
- May 6: QICD/DOO Mtg
- May 6: NACA/EHN CE Overview Code Meeting
- May 7: Luma Checklist Review with Alika
- May 7: Front Desk Luma Final Prep and Review Meeting
- May 7: Leadership Mtg
- May 7: DNPAO Strategy Engagement Communities (SECs) are intended to provide recipients with the opportunity to discuss topics related to the implementation of SPAN/HOP/REACH strategies. During SECs, recipients will address challenges and emerging areas of interest and share successes in a peer-to-peer learning environment supported by DNPAO SEC Coordinators (CDC project officers) and Supporters (CDC science partners). This session will focus on Community Design for Physical Activity. Please share this invitation as appropriate with your team. At least one member of your team should take part in DNPAO SECs for all strategies, required and optional, that are a part of your portfolio for this funding cycle.
- May 8: PBC/BPM/CFO Check In Mtg
- May 8: Relias Workshop Mtg
- May 11: Luma Weekly Call
- May 11: CHR Subcommittee Mtg
- May 12: Grants Committee Mtg
- May 12: Interview CHR
- May 12: Interview CHR
- May 13: QICD/DOO Mtg
- May 13: IMH/NACA Weekly Mtg
- May 13: CIC Study Group Mtg

Family Heath Center Board Report
May 2026
Prepared by: Verity Quiroz, Director of Operations

- May 13: Relias Workshop Mtg
- May 14: Clinical Case Mgmt Mtg
- May 14: CMS AIAN QIO Mtg
- May 15: Coding Review Workgroup
- May 17-20: Tribal UGM in Sacramento
- May 21: All Clinic Staff Mtg
- May 21: NACA Monthly Risk Adj/Quality Review Mtg
- May 21: DUIA Urban Mtg
- May 21: Leadership Mtg
- May 21: Coding Review Workgroup
- May 21: Navajo Area NDW Mtg
- May 26: Tribal CHR Director's Meeting
- May 26: AAPC
- May 26: THNC
- May 27 WCAG Accessibility Compliance
- May 27: IMH/NACA
- May 27: CIC Study Group
- May 27: Operations Committee Meeting
- May 27: HR Retention Committee Meeting
- May 28: Nurse Staff Meeting
- May 28: Director's Meeting
- May 28: CHR Subcommittee Mtg

Travel:

- Verity, Cassie & Shay to Tribal UGM, Sacramento CA, May 2026
- Verity to CHW Summit, Chandler AZ June 2026
- Verity & Shay to National Tribal Health Conference Aug 2026
- Nextgen UGM Annual Conference - pending

Attachments:

- Fonemed Report
- Urban and 1ALOE Reports
- Microorganisms Report

Complete Call Report

Native Americans for Community Action (NACA)

February 2026

Please contact us with any questions by phone or email.

The FONEMED Team

1.800.366.3633 www.fonemed.com reports@fonemed.com

Call Summary

Total Calls For Period:	0
Company Wide Abandonment Rate:	14.21%
Callers who indicated that they will comply with nurses recommendation:	0.0%
Average Speed to Answer:	59.74 seconds
Company Wide Satisfaction Rate:	97.60%

Cost Savings

Nurse Advice Line savings due to redirection*:

Emergency Room Visits:	$0.00
Urgent Care Facility Visits:	$0.00
Doctor Visits:	$0.00
Total:	$0.00

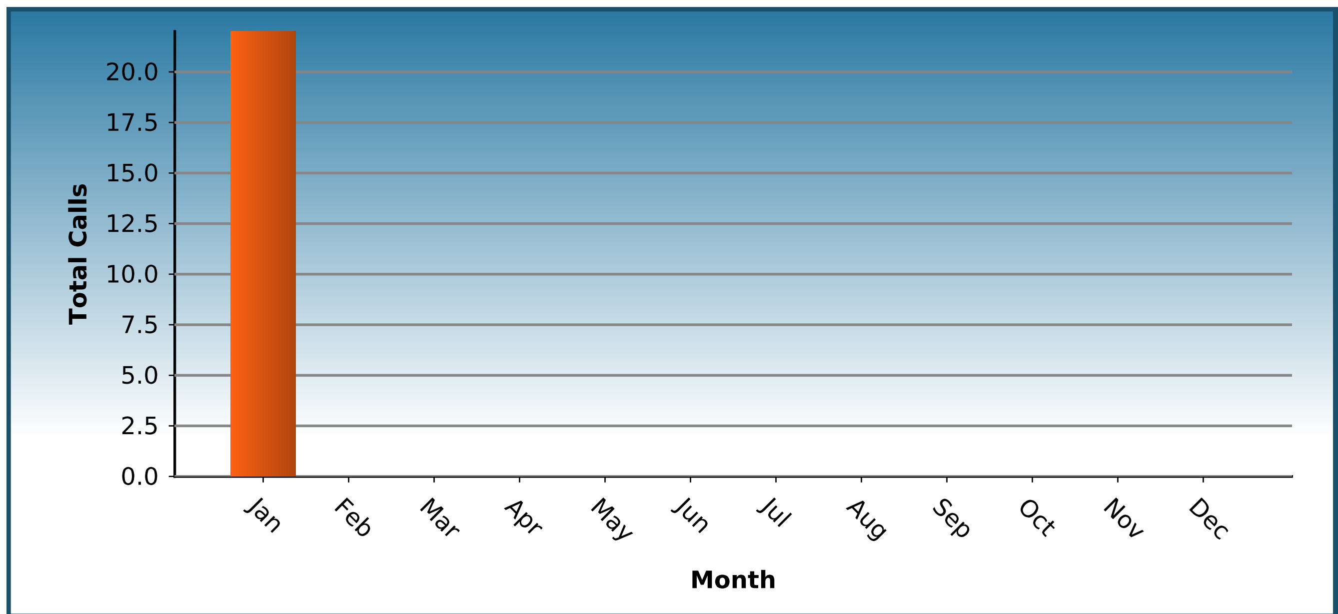
*Estimated National Averages for Health Care Services:

Emergency Room Visits - Source: United Health; Health and Human Services	$1700.00
Urgent Care Facility Visits - Source: United Health; Health and Human Services	$190.00
Physician Office visit: Source: Health and Human Services; National Institute of Health Study	$200.00

*All call times reported in UTC

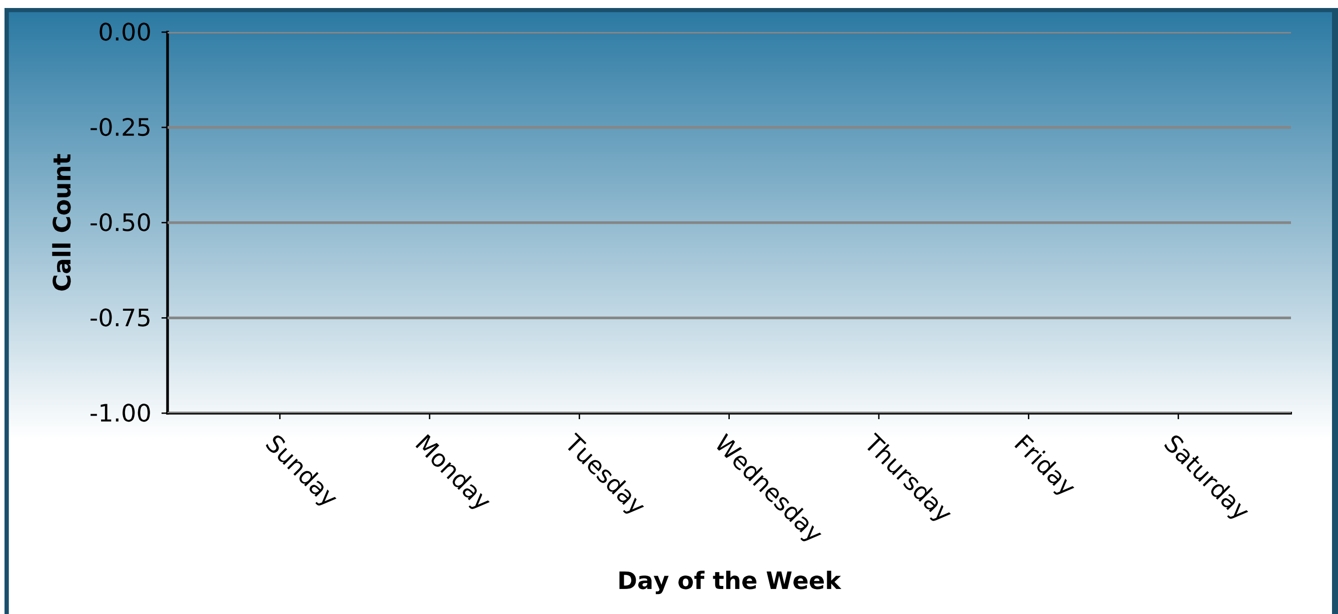
Calls By Month

Report Month	Total Calls
January	22
February	0
March	0
April	0
May	0
June	0
July	0
August	0
September	0
October	0
November	0
December	0



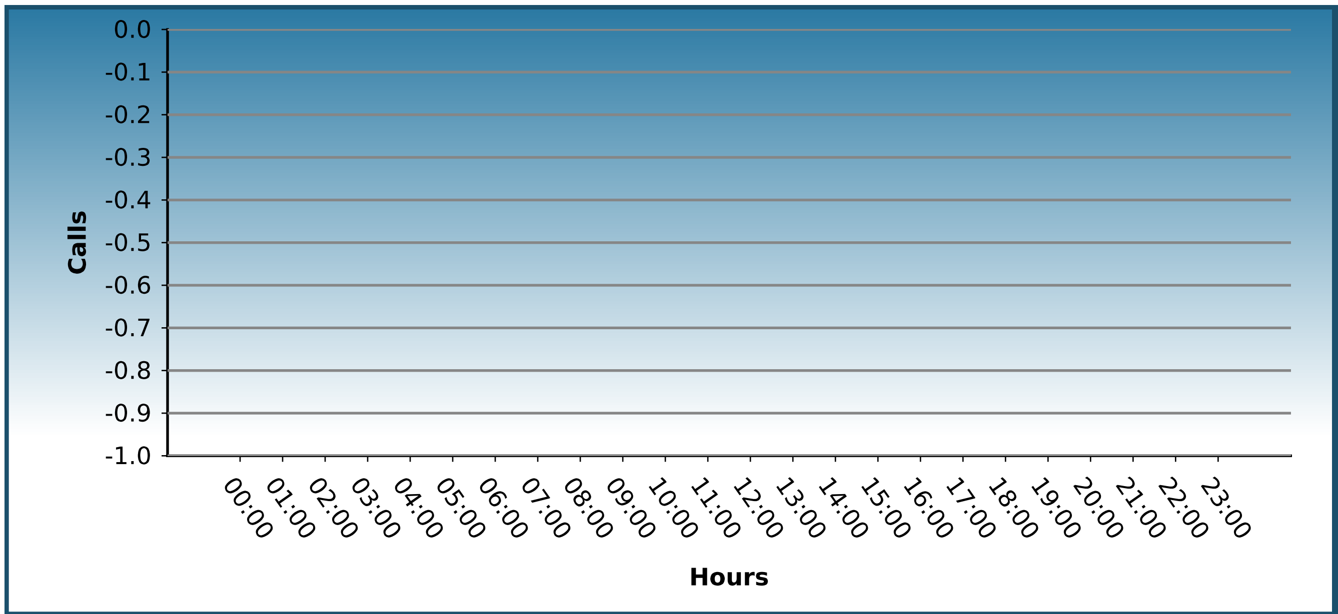
Calls By Weekday

Weekday	Call Count
Sunday	0
Monday	0
Tuesday	0
Wednesday	0
Thursday	0
Friday	0
Saturday	0



Calls By Hour

00:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00	10:00	11:00
0	0	0	0	0	0	0	0	0	0	0	0
12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00
0	0	0	0	0	0	0	0	0	0	0	0



Calls By Redirection

	Call 911	Go to ER	Go to UCF	Called Doctor in AM	Access other service	Nothing / Home Care	Unsure	Question Not Available	Total	Percentage
911 - Emergency	0	0	0	0	0	0	0	0	0	0.0%
Immediate - Urgent Care	0	0	0	0	0	0	0	0	0	0.0%
Contact Medical Care Within 24 Hours	0	0	0	0	0	0	0	0	0	0.0%
Contact Medical Care Within 72 Hours	0	0	0	0	0	0	0	0	0	0.0%
Contact Medical Care Within 2 weeks	0	0	0	0	0	0	0	0	0	0.0%
Home Care	0	0	0	0	0	0	0	0	0	0.0%
Information Provided	0	0	0	0	0	0	0	0	0	0.0%
Total:	0	0	0	0	0	0	0	0	0	0%
Percentage:	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Savings:	$0	$0	$0	$0	$0	$0	$0	$0	$0	

Final Disposition **Original Inclination**

- 911 - Emergency
- Immediate - Urgent Care
- Contact Medical Care Within 24 Hours
- Contact Medical Care Within 72 Hours
- Contact Medical Care Within 2 weeks
- Home Care
- Information Provided

Adult Protocol Counts

Protocol	Protocol Count

Pediatric Protocol Counts

Protocol	Protocol Count

Calls By Age

Age Group	Patient Count
Under 1 Yr	0
01 - 04 Yrs	0
05 - 09 Yrs	0
10 - 18 Yrs	0
19 - 29 Yrs	0
30 - 39 Yrs	0
40 - 49 Yrs	0
50 - 59 Yrs	0
60 - 69 Yrs	0
70+ Yrs	0
Not Specified	0

Calls By Gender

Gender	Patient Count
Female	0
Male	0

Compliance

Comply	Call Count
No	0
Yes	0

NACA
1500 E Cedar Ave
Suite 26
Flagstaff, AZ 86004

1255 W. Washington St
Tempe, AZ 85281
602.685.5000 or 800.766.6721

Account: 76050

Report Date: 05/01/2026 12:03 PM

Approval Date Range: **04/01/2026 - 04/30/2026**

Microorganisms Summary Report

NACA

Culture Type: Urine

Microorganism	Total
Escherichia coli	5
Mixed Gram positive flora	2

URBAN TRANSMISSION REPORTS

Report Date: 10/01/2025 thru 09/30/2026

Today's Date: 04/28/2026 | Data As Of: 03/15/2026

INDIAN HEALTH SERVICE

Urban AREA Data Loaded to the NDW

Report Date: 10/01/2025 thru 09/30/2026

Today's Date: 04/28/2026 | Data As Of: 03/15/2026

Includes data sent in by any site in the report area for services taking place at any site in the report area.

Region Abbr Code	ITU	ASUFAC	Service Taking Place At...	Files
NAV	U	878711	NACA HEALTH CENTER	4

URBAN 1ALOE MONTHLY REPORT

Report Date: 10/01/2025 thru 09/30/2026

Today's Date: 04/28/2026 | Data As Of: 03/15/2026

INDIAN HEALTH SERVICE

OUIHP Notice to Recipient

As a reminder, the urban workload statistics were removed from the official Workload reports generated by the IHS Office of Public Health Support. The urban ‘view’ of the reports follow the same format and naming convention, and continue to provide statistics on all facility types for any of the UIOs that are sending data to the National Data Warehouse (NDW). Please note that low numbers or zeroes shown in the workload reports are likely attributed to UIOs switching to a non-RPMS system, in which case there is usually a delay between switching systems and the ability to report data to the NDW. Once these programs are configured for export, an increase in workload data should begin appearing in the reports.

OUIHP kindly requests you provide the contact information of the individuals at your UIO who are responsible for data file submissions and receiving subsequent notices from the NPIRS team acknowledging when a file has been uploaded to the NDW. If the contact information for these individuals needs to be updated, please contact the Office of Urban Indian Health Programs (OUIHP) at IHSUrbanWorkloadReports@ihs.gov, to provide and update this crucial contact information.

Generated Reports Notice

Blank pages may result depending on the report generator and the flow of the report data.

Blank or empty reports may be generated if one report has data and other does not.

NACA
NATIVE AMERICANS FOR COMMUNITY ACTION

1500 E. Cedar Ave., Suite 26 Flagstaff, Arizona (928) 773-1245

Monthly Meeting of the NACA Board of Directors
HIS Specialist Report – May 2026

Major Highlights

NextGen Patch Update
- Patch 308 was completed in Prod 5/7/2026
- No major issues during upgrade

Luma Project
- Go-Live 5/12/2026
- Rebecca from NextGen was on site to provide support
- Overall go-live went well. Alika took lead with setup, testing and supporting reception staff. He has been crucial to go-live success.
- Continuing to identify workflow adjustments
- Eligibility Configuration has begun

First On-Site Visit
- Assisted staff with some of their current issues and concerns
  - Enrolled new providers to NextGen Virtual Visit
  - Purchased Crystal Reports to update/edit existing NextGen reports
    - Updated Nurses "Medication Visit Sheet"
    - Updated Quest Lab Specimen Labels for printing via Dymo label printer
  - Purchased Dymo label printer and print server – Pending print server delivery for final installation

Major Challenges

NextGen Patch Update
- Day after install, Billing discovered errors when trying to bill encounters.
- Critical Case with NextGen was opened to begin troubleshooting
- As of 5/14 it has been escalated to Tier 2 with the following comment from NextGen support

- *"We continue to review this matter. Preliminary analysis has confirmed the details already provided. However, we will need to engage additional resources for troubleshooting. We understand the urgency and will do our best to work to resolution. We appreciate your continued patience."*
- I am continuing to follow up daily for status updated

Population Health – IHS Reporting
- Continuing to participate in THNC IHS Reporting and NextGen Beta Testing group
- Ongoing EHR configuration to better capture GPRA metric data
- IDA Reporting Audit in-progress

Workload (Risk Level: Pending)
- I am still in the process of picking up where Darlene left off.
- With Cassie now as part of HIS, she is helping pick up end user support on-site.
- Will have NextGen Ticket Analysis next month

Ongoing Projects & Strategic Goals

Luma Project
- Next phase is getting Luma Eligibility configured and live

NextGen 8 Upgrade
- Upgrade to be scheduled following Luma Go-Live

Population Health
- Continued data integrity audit and workflow adjustments

Dymo Label Printer
- Once print server is received, will install for Nurses to be able to print out specimen labels
- Quest Lab Label report has been updated and ready for final review

NACA
NATIVE AMERICANS
FOR COMMUNITY ACTION

Health Promotion & Wellness Center Program

May Meeting-Board Report

Major Highlights

Tribal Practices for Wellness in Indian Country (TPWIC) grant objectives and strategies.

- The 5th-year continuing grant application is under review.
- MMIW event- the event was hosted, it included prayers, a City of Flagstaff Proclamation, a drum group performance, poster making, and an awareness walk.
- Beading Circle is completed.
- Native Food For Life is ongoing.
- The garden blessing is scheduled for May 30th, with a cultural storyteller/speaker to attend the event.

Special Diabetes Program for Indians (SDPI) Program results

- Next-gen electronic records- we are building a Community Health Representative template to continue the Medicaid/ Medicare billable efforts.
- Ongoing clinical support is ongoing for foot checks, Retinopathy exams, physical education and health education.
- Honor your Heart completed
- Just Move it – HP will be present assisting with the Just Move It event at Ft Tuthill, and at the Grand Finale in Tuba City.
- What Can I Eat? Healthy Choices for American Indians and Alaska native's class. This is an American Diabetes Association class hosted over 5 weeks. This class has started.

4 in 1 Grant

- Pathways children have sessions each week focusing on exercise, nutrition, and cultural activities. The gardening lessons and food demonstrations are taking place.
- Community Cooking class – NACA HP will be partnering with the Flagstaff Food Bank and the Flagstaff Sustainability Department in a pilot project to host 6 classes. Participants will learn cooking techniques, nutritious recipes, and practical kitchen skills. The classes start this week.

Az Cancer Coalition mini grant

- Colon Cancer preventative kits (FITT kits) are being distributed to patients due for the screening. Preventive screening is being incentivized for patients.

NACA
NATIVE AMERICANS
FOR COMMUNITY ACTION

Behavioral Health

April's #s for May 2026 Meeting-Board Report

Mental Health Contacts: Aug 486, Sep 599, Oct 632, Nov 486, Dec 511, Jan 566, Feb 524, Mar 612, Apr 642
Substance Abuse Contacts: Aug 216, Sep 251, Oct 336, Nov 262, Dec 232, Jan 249, Feb 243, Mar 312, Apr 330
New Intakes: Aug 49, Sep 36, Oct 56, Nov 49, Dec 40, Jan 55, Feb 53, Mar 77, Apr 77
Total Encounters: Aug 751, Sep 886, Oct 1024, Nov 797, Dec 783, Jan 870, Feb 820, Mar 1,001, Apr 1049

Major Highlights:

April saw a lot of meetings to get ready for Luma, Relias, and prepare for the Sacred Mountain Prayer Run.

Monica Whicker completed her last live supervision requirement toward licensure. Monica, Kyra Vandervere, and Teri Navakuku are all within 2 months of obtaining independent licensure.

April involved a lot of planning between NAU and NACA to bring the Flash Technique training back to Flagstaff for a second year. Dr. Dan Mitchell, PhD, former NAU graduate, conducted the training on April 22nd at the DuBois Center. 98 people signed up for the training, and we had attendees from Polacca, Nogales, Second Mesa, Tuba City, Dilkon, Phoenix, and Tucson. The training was well attended and a huge success providing 6.5 CEs to many professionals and community members.

Another milestone reached in April was completion of our HRSA review. We are now able to offer nurses and counselors with student loans, debt relief until 12/31/2030!

Ongoing Projects:

- Participation on the QI/QA Committee ongoing
- Participation on the Medical Executive Committee ongoing
- Participation on Directors and Leadership Committee ongoing
- Conduct individual and group supervision weekly.
- Participation in the Employee Retention Committee.
- Participation in the Operations Committee.

Curtis Randolph PhD, LPC, Director of Behavioral Health