NACA
NATIVE AMERICANS
FOR COMMUNITY ACTION

# BOARD MEETING PACKET

## June 17, 2026


**NACA Main Office**
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**Flagstaff, Az. 86004**
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# AGENDA

Monthly Meeting of Board of Directors
In-Person Meeting at Hopi Room
June 17, 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 June 17, 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 | |

**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)

   June 17, 2026 Board Agenda

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

   May 20, 2026 Board Minutes

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

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

   1) Kristin Poorman – Community Health Representative

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
- Revision: MS 100 Triage Procedure
- Revision: MS 110 Emergency Patient Transfers
- Revision: MS 120 Patient Centered Medical Home Model Policy
- Revision: MS 130 Allergy Assessment
- Revision: MS 200 Practice Guidelines & Professional Scope Governance
- Consolidated: MS 210 Clinical Practice Guidelines for Nurse Providers
- Revision: MS 220 Clinical Practice Guidelines for Advanced Practice Providers
- Revision: MS 225 Clinical Practice Guidelines for Nurses (RNs & LPNs)
- Revision: MS 230 Clinical Practice Guidelines for Medical Assistants
- Revision: MS 300 Preventative Care Guidelines for Adults Patients (18 – 65+ years)
- Revision: MS 310 Clinical Care Guidelines for Adult Patients with Hypertension
- Revision: MS 320 Clinical Care Guidelines for Patients with Diabetes
- Consolidated: MS 321 Fundoscopic Evaluations for Patients with Diabetes
- Consolidated: MS 322 Standing Orders for Adult Patients with Diabetes
- Revision: MS 331 Cancer Screening Standing Orders for Adult Patients
- Revision: MS 340 Medical Procedures
- Revision: MS 350 Geriatric Care
- Revision: MS 360 Pediatric Care (Birth – 17 years)
- Revision: MS 400 Chronic Non-Cancer Pain Management
- Revision: MS 410 Assessment and Management of Acute Pain
- Revision: MS 500 HIV Testing and Counseling
- Revision: MS 600 Additional Attendants During Examination
- Revision: MS 610 Disclosure of Diagnosis and Prognosis
- Revision: MS 620 Hospitalization and Transition of Care
- Revision: MS 630 Standing Orders for Point of Care Testing in Symptomatic Patients
- Consolidated: MS 640 Time Out Prior to Invasive Procedures
- Revision: MS 650 Student and Volunteer Observers
- Revision: MS 660 Provider Presence in Primary Care Setting
- Revision: MS 670 Clinical Care Area Access
- New: MS 680 Routine Depression Screening in Patients Aged 8 and Older
- Revision: MS 700 Patient Discharge or Refused Care from Practice
- Revision: MS 710 Patient Education
- Revision: MS 720 Purchased/Referral Care (PRC) Policy
- Revision: MS 800 Management of Medical Sharps
- Consolidated: MS 810 Medication and Vaccine Room Access Policy
- Consolidated: MS 820 Point of Care Laboratory Access Policy
- Revision: MS 900 Expedited Partner Therapy for Sexually Transmitted Infections
- Revision: MS 920 Nursing Competencies
- Consolidated: MS 930 Referred Care
- Revision: MS 940 Healthcare Laboratory and Imaging Follow-up
- Revision: MS 950 Use of Anesthetics
- Revision: MS 960 Minimum Emergency Equipment & Supplies
- New: MS 970 Medication, Medical Supply, and Medical Equipment Procurement

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: Start Date – July 13, 2026
      - Dr. Arhin: Last Day – July 31, 2026

9. **New Business**

**Next Board Meeting Date:** July 15, 2026 at 5:30 p.m.

**Adjournment of Meeting:**

# MEETING MINUTES

# MAY 20, 2026

Monthly Meeting of Board of Directors
In-Person Meeting at Hopi Room
May 20, 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 – E | Juliette Roddy, Vice-President – P | Vacant, Treasurer |
| Vacant, Secretary | Charles Doughty – P | Victoria Tewa – P |
| Rachael Baker – P | Melinda Smith – P | ~~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** – Offered by Christopher David.

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

   May 20, 2026 Board Agenda

   *Motion to **adopt and approve** with removal of Skyler Bordeaux from the Board Members listing.*
   Motion: Rachael Baker  Second: Victoria Tewa
   Yes: 4  No: 0  Abstain: 0

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

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

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

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

   No public participation.

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

   No 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

      *Motion to **adopt and approve** as provided.*
      Motion: Rachael Baker  Second: Victoria Tewa
      Yes: 4  No: 0  Abstain: 0

   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

      *Motion to **adopt and approve** as provided.*

Motion: Rachael Baker  Second: Charles Doughty
Yes: 4  No: 0  Abstain: 0

C. NACA Logo Package (ACTION) – Almalia Berrios

*Motion to **adopt and approve** as provided.*
Motion: Charles Doughty  Second: Victoria Tewa
Yes: 4  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

**9. New Business**

**Next Board Meeting Date:** June 17, 2026 at 5:30 PM

**Adjournment of Meeting:** May 20, 2026 at 7:12 PM

# CONSENT ITEMS

# NATIVE AMERICANS FOR COMMUNITY ACTION, INC. (NACA)

## Medical Services (MS) Policy Manual – Summary of Changes

Prepared for Board of Directors Review • June 2026

### Board Review Context

A comprehensive review of all Medical Services policies was completed during FY 2025–2026. The majority of revisions are administrative and structural in nature, intended to align policy management with AAAHC accreditation expectations and strengthen governance oversight. The Board of Directors is being asked to approve the policy-level direction for each of these documents. Operational procedures and clinical protocols — which are maintained and updated by clinical leadership and the Medical Director — are no longer subject to Board approval under the revised framework.

Policies with a Board Impact rating of Moderate have been reviewed by clinical leadership and/or the Medical Director prior to submission. New and Consolidated entries reflect the addition of two new policies and the consolidation of seven previously standalone policy numbers into related policies.

| Policy # | Policy Name | Review Type | Change Category | Board Impact | Summary of Change |
|---|---|---|---|---|---|
| MS 100 | Triage Procedure | Revision | Formatting / Governance | Low | Reformatted into new AAAHC-aligned structure. Policy, Procedure, and Protocol separated. Added Purpose, Scope, Governance, Guidelines, and References. No substantive change to triage intent. |
| MS 110 | Emergency Patient Transfers | Revision | Formatting / Governance | Low | Reformatted with new structure. Transfer expectations and EMS activation clarified in procedure/protocol layer. No substantive change to policy intent. |
| MS 120 | Patient Centered Medical Home Model Policy | Revision | Formatting / Governance | Low | Reformatted with standardized sections. PCMH policy intent unchanged. |
| MS 130 | Allergy Assessment | Revision | Formatting / Governance | Low | Reformatted into standardized policy structure. Procedure/protocol content separated. No substantive change to policy intent. |
| MS 200 | Practice Guidelines & Professional Scope Governance | Revision | Structural Consolidation / Governance | Low | Retitled and expanded to address professional scope governance. Consolidates prior Medical Director and provider scope/practice guideline content. Adds clearer ownership and governance language. |
| MS 210 | Clinical Practice Guidelines for Nurse Providers | Consolidated | Structural Consolidation | N/A | No longer a standalone policy. Content addressed through MS 200 and the updated provider/scope governance structure. |
| MS 220 | Clinical Practice Guidelines for Advanced Practice Providers | Revision | Formatting / Governance | Low | Reformatted with standardized sections and clearer governance. No substantive change to policy intent. |

| Policy # | Policy Name | Review Type | Change Category | Board Impact | Summary of Change |
|---|---|---|---|---|---|
| MS 225 | Clinical Practice Guidelines for Nurses (RNs & LPNs) | Revision | Formatting / Governance | Low | Reformatted with standardized sections and clearer governance. No substantive change to policy intent. |
| MS 230 | Clinical Practice Guidelines for Medical Assistants | Revision | Formatting / Governance | Low | Reformatted with standardized sections and clearer governance. No substantive change to policy intent. |
| MS 300 | Preventive Care Guidelines for Adult Patients (18–65+ years) | Revision | Formatting / Governance | Low | Reformatted with standardized sections. Guidelines clarified and references updated. No substantive operational change. |
| MS 310 | Clinical Care Guidelines for Adult Patients with Hypertension | Revision | Clinical Revision | Moderate | Substantive clinical protocol update. Updated BP thresholds and hypertension management guidance aligned with current clinical standards. Medical Director reviewed prior to Board submission. |
| MS 320 | Clinical Care Guidelines for Patients with Diabetes | Revision | Clinical Revision | Moderate | Substantive clinical protocol update. Updated diabetes management guidance including GLP-1 receptor agonist considerations, kidney function, diabetic eye and foot care, and broader chronic disease risk management. Medical Director reviewed prior to Board submission. |
| MS 321 | Fundoscopic Evaluations for Patients with Diabetes | Consolidated | Structural Consolidation | N/A | No longer a standalone policy. Fundoscopic evaluation requirements incorporated into MS 320 Diabetes Care guidance and protocol. |
| MS 322 | Standing Orders for Adult Patients with Diabetes | Consolidated | Structural Consolidation | N/A | No longer a standalone policy. Standing order content incorporated within MS 320 diabetes policy and protocol materials. |
| MS 331 | Cancer Screening Standing Orders for Adult Patients | Revision | Operational / Clinical Clarification | Moderate | Reformatted and expanded into new structure. Standing order and screening workflow language clarified. Reviewed by clinical leadership prior to Board submission. |
| MS 340 | Medical Procedures | Revision | Structural Consolidation / Operational | Moderate | Reformatted and expanded to incorporate procedural expectations previously maintained separately, including time-out verification requirements. Reduces the need for a standalone MS 640 policy. |
| MS 350 | Geriatric Care | Revision | Formatting / Governance | Low | Reformatted with standardized sections, governance, and references. No substantive change to policy intent. |

| Policy # | Policy Name | Review Type | Change Category | Board Impact | Summary of Change |
|---|---|---|---|---|---|
| MS 360 | Pediatric Care (Birth–17 years) | Revision | Formatting / Governance | **Low** | Reformatted with standardized sections, governance, and references. No substantive change to policy intent. |
| MS 400 | Chronic Non-Cancer Pain Management | Revision | Operational / Clinical Clarification | **Moderate** | Reformatted and clarified. Controlled substance management workflows verified by clinical leadership prior to Board submission. |
| MS 410 | Assessment and Management of Acute Pain | Revision | Operational / Clinical Clarification | **Moderate** | Reformatted and clarified. Acute pain assessment and management workflows verified by clinical leadership prior to Board submission. |
| MS 500 | HIV Testing and Counseling | Revision | Formatting / Governance | **Low** | Reformatted with standardized sections and references. Procedure/protocol content clarified. No substantive change to policy intent. |
| MS 600 | Additional Attendants During Examination | Revision | Formatting / Governance | **Low** | Reformatted with standardized sections. No substantive change to policy intent. |
| MS 610 | Disclosure of Diagnosis and Prognosis | Revision | Formatting / Governance | **Low** | Reformatted with standardized sections. No substantive change to policy intent. |
| MS 620 | Hospitalization and Transition of Care | Revision | Operational Clarification | **Low** | Retitled from Tracking and Hospitalized Patients. Clarifies tracking, follow-up, and continuity-of-care expectations. |
| MS 630 | Standing Orders for Point of Care Testing in Symptomatic Patients | Revision | Operational / Clinical Clarification | **Moderate** | Reformatted and clarified. Standing order language reviewed by clinical leadership to ensure accuracy of clinical testing workflows. |
| MS 640 | Time Out Prior to Invasive Procedures | Consolidated | Structural Consolidation | **N/A** | No longer a standalone policy. Time-out verification expectations incorporated into MS 340 Medical Procedures. |
| MS 650 | Student and Volunteer Observers | Revision | Formatting / Governance | **Low** | Reformatted with standardized sections. No substantive change to policy intent. |
| MS 660 | Provider Presence in Primary Care Setting | Revision | Formatting / Governance | **Low** | Reformatted with standardized sections. No substantive change to policy intent. |
| MS 670 | Clinical Care Area Access | Revision | Structural Consolidation / Operational | **Moderate** | Retitled from Patient Care Area Access. Expanded to regulate access to patient care areas, medication/vaccine rooms, and point-of-care laboratory spaces, consolidating content from prior MS 810 and MS 820. |

| Policy # | Policy Name | Review Type | Change Category | Board Impact | Summary of Change |
|---|---|---|---|---|---|
| MS 680 | Routine Depression Screening in Patients Aged 8 and Older | **New** | New Policy | **Moderate** | New policy adopted February 2025. Establishes standardized PHQ-9 depression screening for patients aged 8 and older at every clinical visit. Includes standing order authorization, warm hand-off referral process, and suicidal ideation response protocol. Board approved February 19, 2025. |
| MS 700 | Patient Discharge or Refused Care from Practice | Revision | Formatting / Governance | **Low** | Reformatted with standardized sections and clearer governance. No substantive change to policy intent. |
| MS 710 | Patient Education | Revision | Formatting / Governance | **Low** | Reformatted with standardized sections. No substantive change to policy intent. |
| MS 720 | Purchased/Referral Care (PRC) Policy | Revision | Operational Clarification | **Low** | Reformatted and referral/purchased care expectations clarified. Referral workflow language reduces the need for a standalone MS 930 policy. |
| MS 800 | Management of Medical Sharps | Revision | Formatting / Governance | **Low** | Reformatted with standardized sections and references. No substantive change to policy intent. |
| MS 810 | Medication and Vaccine Room Access Policy | Consolidated | Structural Consolidation | **N/A** | No longer a standalone policy. Access control content incorporated into MS 670 Clinical Care Area Access. |
| MS 820 | Point of Care Laboratory Access Policy | Consolidated | Structural Consolidation | **N/A** | No longer a standalone policy. Access control content incorporated into MS 670 Clinical Care Area Access. |
| MS 900 | Expedited Partner Therapy for Sexually Transmitted Infections | Revision | Operational / Clinical Clarification | **Moderate** | Reformatted and clarified. Public health treatment workflows reviewed by clinical leadership to verify current legal and practice references. |
| MS 920 | Nursing Competencies | Revision | Operational Clarification | **Low** | Reformatted and competency expectations clarified. No substantive change to policy intent. |
| MS 930 | Referred Care | Consolidated | Structural Consolidation | **N/A** | No longer a standalone policy. Referral-care workflows addressed through MS 720 and related transition/follow-up policies. |
| MS 940 | Healthcare Laboratory and Imaging Follow-up | Revision | Operational Clarification | **Low** | Reformatted and follow-up expectations clarified. No substantive change to policy intent. |
| MS 950 | Use of Anesthetics | Revision | Operational / Clinical Clarification | **Moderate** | New policy adopted November 2024. Reformatted and expanded. Anesthetic use is a clinical safety topic; protocol details and current standards verified by clinical leadership prior to Board submission. |

| Policy # | Policy Name | Review Type | Change Category | Board Impact | Summary of Change |
|---|---|---|---|---|---|
| MS 960 | Minimum Emergency Equipment & Supplies | Revision | Operational / Clinical Clarification | **Moderate** | New policy adopted November 2024. Establishes minimum emergency equipment and supply requirements. Equipment list and monitoring requirements verified by clinical leadership prior to Board submission. |
| MS 970 | Medication, Medical Supply, and Medical Equipment Procurement | **New** | New Policy | **Low** | New policy adopted April 2026. Establishes standardized procedures for the selection, purchasing, receiving, and replacement of medications, medical supplies, and medical equipment across NACA clinical programs. |

## Legend – Board Impact Rating

| | |
|---|---|
| **Low** | Structural/formatting revision; no substantive change to policy direction or patient care practice. |
| **Moderate** | Operational or clinical clarification; clinical leadership and/or Medical Director have reviewed prior to Board submission. |

**List of Medical Services (MS) Policies:**

| | |
|---|---|
| MS 100 | Triage Procedure |
| MS 110 | Emergency Patient Transfers |
| MS 120 | Patient Centered Medical Home Model Policy |
| MS 130 | Allergy Assessment |
| MS 200 | Practice Guidelines & Professional Scope Governance |
| MS 220 | Clinical Practice Guidelines for Advanced Practice Providers |
| MS 225 | Clinical Practice Guidelines for Nurses (RNs & LPNs) |
| MS 230 | Clinical Practice Guidelines for Medical Assistants |
| MS 300 | Preventive Care Guidelines for Adult Patients (18 – 65+ years) |
| MS 310 | Clinical Care Guidelines for Adult Patients with Hypertension |
| MS 320 | Clinical Care Guidelines for Patients with Diabetes |
| MS 331 | Cancer Screening Standing Orders for Adult Patients |
| MS 340 | Medical Procedures |
| MS 350 | Geriatric Care |
| MS 360 | Pediatric Care (Birth – 17 years) |
| MS 400 | Chronic Non-Cancer Pain Management |
| MS 410 | Assessment and Management of Acute Pain |
| MS 500 | HIV Testing and Counseling |
| MS 600 | Additional Attendants During Examination |
| MS 610 | Disclosure of Diagnosis and Prognosis |
| MS 620 | Hospitalization and Transition of Care |
| MS 630 | Standing Orders for Point of Care Testing in Symptomatic Patients |
| MS 650 | Student and Volunteer Observers |
| MS 660 | Provider Presence in Primary Care Setting |
| MS 670 | Clinical Care Area Access |
| MS 680 | Policy and Standing Order for Routine Depression Screening in Patients Aged 8 and Older |
| MS 700 | Patient Discharge or Refused Care from Practice |
| MS 710 | Patient Education |
| MS 720 | Purchased/Referral Care (PRC) Policy |
| MS 800 | Management of Medical Sharps |
| MS 900 | Expedited Partner Therapy for Sexually Transmitted Infections |
| MS 920 | Nursing Competencies |
| MS 940 | Healthcare Laboratory and Imaging Follow-up |
| MS 950 | Use of Anesthetics |
| MS 960 | Minimum Emergency Equipment & Supplies |
| MS 970 | Medication, Medical Supply, and Medical Equipment Procurement |

| | | |
|---|---|---|
| **POLICY: MS 100** | (X) Revision<br>( ) New | Original Issue Date: 02/15/05<br>Revised Date: 09/04/20; 07/31/23; 06/02/25 |
| **Patient Triage** | Author: Medical Staff Committee | Approved by: Board of Directors<br>Approval Date: 09/16/20; 07/17/24; 06/11/25<br>Effective Date: 09/17/20; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |

**I. POLICY:** The policy of NACA is to ensure adequate and timely medical care is provided to patients according to the acuity of their medical condition.

**II. PURPOSE:** To ensure efficient and effective care by prioritizing patient needs based on the severity of their condition, optimizing allocation of resources, and providing timely access to appropriate healthcare services.

**III. SCOPE:** Applies to all staff who are involved in patient intake, triage, and clinical care.

**IV. GOVERENANCE:** Triage protocols and standing orders are approved by the Medical Director and reviewed annually.

**V. GUIDELINES:**

A. Patients with scheduled appointments shall be seen first, unless the patient's medical condition indicates an emergency situation as determined by the nurse and/or medical provider.
B. Same-day appointments are reserved for patients with acute illness but may be filled with routine follow-ups or medication refills if not otherwise needed.
C. The Patient Services Coordinator (PSC) shall use the Screening and Routing Grid when determining patient acuity and who to notify.
D. The PSC may refer established patients to a medical assistant and/or the registered nurse for triage. Any recommendations made by the MA and/or the RN shall be documented in the Electronic Health Record (EHR).
E. All new patients shall be scheduled as a NEW patient appointment in the EHR. A patient is considered new if not seen ever or not seen within 3 years.

**VI. REFERENCES:**

A. CDC Emergency Warning Signs
B. AAAHC Standards for Clinical Care

**MS100A TRIAGE PROCEDURE:**

1. Patient Presentation
    - Patients present via check-in, call, or walk-in.
    - The Patient Services Coordinator (PSC) initiates triage screening.

2. Initial Screening
    - PSC obtains presenting complaints and basic identifiers.
    - PSC assesses obvious distress or emergency indicators.

3. Use of Screening and Routing Grid Tool
    - PSC utilizes the approved Screening and Routing Grid (MS100B Appendix) to determine acuity and next steps.

4. Escalation
    - Based on triage criteria:
    a. Emergent conditions → Immediately notify RN and Provider; activate EMS if required.
    b. Urgent conditions → Notify RN for clinical triage
    c. Routine conditions → Schedule appropriately.

5. Clinical Triage (RN/Provider)
    - RN performs further assessment when indicated.
    - Provider involvement occurs per protocol or RN escalation.

6. Documentation
    - All triage interactions must be documented in the EHR, including:
    a. Chief Complaint
    b. Triage Decision
    c. Staff Involved
    d. Time of escalation (if applicable)

7. Follow-up
    - Patients are scheduled, referred, or transferred by triage outcome.
    - Any delays or deviations must be documented and reviewed.

8. Compliance and Monitoring:
    - Random chart audits of triage documentation
    - Review of emergency escalation response times

**MS100B TRIAGE PROTOCOL**

I. **PURPOSE:** This protocol provides standardized clinical criteria for decision-making and escalation.

II. **EMERGENT CRITERIA**: ANY of the following require IMMEDIATE escalation to the RN/ Provider and activation of EMS if appropriate:
- Chest pain or pressure
- Difficulty breathing / shortness of breath
- Altered mental status (confusion, disorientation)
- Uncontrolled bleeding
- Suspected stroke symptoms (facial droop, weakness, speech difficulty)
- Suicidal ideation or behavioral health crisis
- Severe allergic reaction (anaphylaxis)
- Oxygen saturation < 90% (if known)

III. **URGENT CRITERIA:** Require same-day RN or Provider evaluation:
- Fever > 102°F
- Persistent vomiting or diarrhea
- Severe Pain pain
- Suspected fracture
- Medication reaction without airway compromise
- Behavioral health concerns without active crisis

IV. **ROUTINE CRITERIA:** Appropriate for scheduled appointments:
- Medication Refills
- Stable Chronic Conditions
- Routine Follow-Ups
- Minor Symptoms

V. **VITAL SIGN THRESHOLDS:** Escalate immediately if any of the following are identified:
- Oxygen Saturation <90%
- Heart Rate > 130 or < 50
- Blood pressure > 180/110 or < 90 systolic
- Temperature > 102 °F
- Blood glucose < 70 or > 300

**MS 100B APPENDIX: Screening and Routing Grid**

| Situation: | Notify Nurse | Notify Medical Provider | Notify Behavioral Health | Complete Incident Report |
|---|---|---|---|---|
| Severe chest pains | X | X | | X |
| Difficulty Breathing / Shortness of Breath | X | X | | |
| Uncontrolled Bleeding | X | X | | |
| Threatened/closed airway | X | X | | |
| Poisoning/suspected overdose | X | X | | |
| Head trauma | X | X | | |
| Suspected Stroke Symptoms (facial droop, speech difficulty, weakness) | X | X | | |
| Suicidal ideation | X | X | X | |
| Altered Mental Status (confusion, disorientation) | X | X | | |
| Moderate or Severe pain | X | X | | |
| Severe Allergy Reaction (anaphylaxis) | X | X | | |
| Fever > 102°F | X | X | | |
| Suspected fracture | X | | | |
| Vomiting/diarrhea | X | | | |
| Intoxicated patient | X | | X | X |
| Threatening/violent patient | X | X | X | X |
| ***Patient Requests:*** | | | | |
| Diagnosis | X | | | |
| Test results | X | | | |
| Medication changes/refills | X | | | |

| | | |
|---|---|---|
| **POLICY: MS 110** | (X) Revision<br>( ) New | Original Issue Date: 07/31/23<br>Revised Date: 10/01/23; 07/12/24<br>Approved by: Board of Directors<br>Approval Date: 10/07/23; 07/17/24; 06/11/25<br>Effective Date: 10/08/23; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |
| **Emergency Patient Transfers** | Author: Medical Staff Committee | |

**I.** **POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to ensure that all patients experiencing emergent conditions are promptly identified, stabilized within the capability of the clinic, and safely transferred to an appropriate higher level of care.

**II.** **PURPOSE:** To ensure timely, coordinated, and medically appropriate transfer of patients requiring emergency or higher-level care while minimizing risk and ensuring continuity of care.

**III.** **SCOPE:** Applies to all clinical and non-clinical staff involved in patient care, triage, stabilization, and transfer processes.

**IV.** **GOVERNANCE:** All emergency transfer procedures and protocols are approved by the Medical Director and reviewed annually in accordance with AAAHC standards and applicable federal and state regulations.

**V.** **REFERENCES:**

A. AAAHC Emergency Care Standards
B. CDC Emergency Warning Signs
C. EMTALA principles (as applicable to the ambulatory setting)

**MS110A EMERGENCY TRANSFER PROCEDURE:**

1. Recognition of Emergency
    - Any staff member identifying a potential emergency condition must immediately notify clinical staff.
    - The patient must not be left unattended.

2. Initiation of Emergency Response
    - Activate emergency response by calling 911 for life-threatening conditions.
    - Notify the on-site Provider and RN immediately.

3. Clinical Assessment and Stabilization
    - The Provider (or RN within scope) performs immediate clinical assessment.
    - Staff initiate stabilization measures within clinic capability, including: Airway support, Oxygen, administration, Bleeding control, and Basic life support (BLS)

4. Coordination of Transfer
    - EMS is utilized for all unstable or emergent patients.
    - Receiving facility (e.g., Flagstaff Medical Center) is notified when possible.
    - Transfer decision and level of transport (BLS, ALS, CCT) are determined by the Provider.

5. Documentation
    - Document in the EHR: Time emergency identified, Clinical findings, Interventions performed, Time EMS activated, Transfer destination, and Staff involved

6. Transfer of Information
    - Provide EMS with relevant patient information: Chief complaint, Medical history, Medications and allergies, Interventions performed, Send or transmit clinical records to receiving facility when possible.

7. Post-Transfer Follow-Up
    - Document transfer completion.
    - Initiate follow-up tracking per MS 620 (Hospitalized Patient Tracking).
    - DOCUMENTATION REQUIREMENTS: All emergency events, interventions, and transfers must be fully documented in the EHR and authenticated by a licensed provider.

8. COMPLIANCE AND MONITORING:
    - Incident review for all emergency transfers
    - Periodic chart audits
    - Review of EMS activation, timing and appropriateness

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# MS110B EMERGENCY TRANSFER CLINICAL PROTOCOL

## I. PURPOSE

- To establish standardized clinical criteria for identifying unstable patients and initiating appropriate stabilization and transfer processes.

## II. CRITERIA FOR UNSTABLE / EMERGENT PATIENTS

**➞ Immediate EMS activation required if ANY present:**

- Chest pain suggestive of cardiac origin
- Severe shortness of breath or respiratory distress
- Altered mental status (confusion, decreased responsiveness)
- Signs of stroke (FAST: facial droop, arm weakness, speech difficulty)
- Uncontrolled bleeding
- Suspected overdose or poisoning
- Seizure activity
- Severe trauma or head injury
- Suicidal ideation or behavioral health crisis

## III. VITAL SIGN THRESHOLDS

Immediate escalation required if:

- Oxygen saturation < 90%
- Heart rate > 130 or < 50
- Blood pressure > 180/110 with symptoms OR < 90 systolic
- Respiratory rate > 30 or < 8
- Temperature > 102°F with systemic symptoms
- Blood glucose < 70 or > 400

## IV. PRE-TRANSFER STABILIZATION EXPECTATIONS

➞ Must occur **within clinic capability only (do not delay EMS)**

- Maintain airway patency
- Administer oxygen as indicated
- Initiate CPR/BLS if needed
- Control hemorrhage
- Position patient appropriately (e.g., supine, recovery position)
- Administer emergency medications if authorized and available (e.g., epinephrine, glucose, naloxone)

## V. TRANSPORT REQUIREMENTS

- Unstable patients MUST be transported via EMS.
- Use of private vehicles or rideshare is prohibited for emergent conditions.
- Stable patients may only use alternative transport if explicitly approved by Provider and documented.

## VI. AUTHORITY AND SCOPE

- All actions are performed under Medical Director-approved protocols.
- Staff must act within scope of practice:
- PSC: Recognition and notification only
- MA: Assist and escalate
- RN: Clinical assessment and intervention
- Provider: Final clinical decision-making

## VII. DOCUMENTATION REQUIREMENTS

The following must be documented:

- Clinical trigger for transfer
- Vital signs (if obtained)
- Stabilization measures provided
- Time EMS activated
- Provider decision and rationale

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| **POLICY: MS 120** | (X) Revision<br>( ) New | Original Issue Date: 03/04/24<br>Revised Date: 03/10/24; 07/12/24; 11/11/24 |
| **Patient Centered Medical Home Model Policy** | Author: Medical Staff Committee | Approved by: Board of Directors<br>Approval Date: 03/20/24; 07/17/24; 11/20/24; 06/11/25<br>Effective Date: 03/21/24; 07/18/24; 12/02/24; 06/12/25<br>Annual Review Date: 06/11/25 |

**I. POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to deliver patient-centered, coordinated, accessible, and high-quality healthcare through the Patient-Centered Medical Home (PCMH) model. Care shall be organized around the whole person and delivered through team-based, culturally responsive, and evidence-based practices.

**II. PURPOSE:** To establish organizational standards that support comprehensive care coordination, patient engagement, and improved health outcomes.

**III. SCOPE:** This policy applies to all clinical and administrative staff involved in patient care, care coordination, and patient engagement activities at NACA.

**IV. STANDARDS:**

- Patient-centered care that respects patient preferences, culture, and values
- Team-based care coordination across providers and services
- Timely access to care, including same-day and after-hours support
- Use of evidence-based guidelines and quality improvement processes
- Integration of behavioral health and social determinants of health

**V. GOVERNANCE:** The Medical Director of NACA oversees the implementation of PCMH standards. All related procedures and workflows are reviewed annually.

**VI. REFERENCES:**

- AAAHC Care Coordination Standards
- HRSA/UDS Quality Measures
- Indian Health Service (IHS) and Tribal Health Care Models

## MS120A CARE COORDINATION PROCEDURE

1. Assignment of Primary Care Provider (PCP)
    - Each patient receiving care at NACA is assigned to a primary care provider (PCP) responsible for coordination of care.

2. Care Team Structure: Patients are supported by a multidisciplinary team, which may include:
    - Medical Provider (MD/DO/NP/PA)
    - Registered Nurse (RN)
    - Medical Assistant (MA)
    - Behavioral Health staff, as appropriate

3. Coordination Across Services
    - Referrals to specialty care, behavioral health, and community resources are initiated based on patient needs.
    - All referrals are tracked to completion in accordance with MS 720 (Referred Care & Purchased/Referred Care Policy).

4. Continuity of Care: NACA coordinates care across:
    - Primary care services
    - Specialty providers
    - Hospitals and emergency departments
    - Community resources and support services

5. Communication:
    - Care plans, diagnostic results, and follow-up instructions are clearly communicated to patients.
    - All communications are documented in the electronic health record (EHR).

6. Follow-Up: Patients receive timely follow-up after:
    - Outpatient visits
    - Hospitalizations or emergency department visits
    - Referrals to external services

DOCUMENTATION REQUIREMENTS:
- All care coordination activities must be documented in the EHR
- Referrals must be tracked and documented to completion
- Follow-up actions and patient communications must be recorded

COMPLIANCE AND MONITORING:
- Referral completion rates are monitored
- Chart audits assess documentation of care coordination
- UDS/GPRA quality measures are reviewed regularly

**MS120B PATIENT ENGAGEMENT & COMMUNICATION STANDARDS**

I. Patient Participation
- Patients receiving care at NACA are encouraged to actively participate in healthcare decision-making.
- Shared decision-making is used when appropriate.

II. Patient Education: Patients are provided with education regarding:
- Diagnoses and conditions
- Treatment options
- Preventive care and screenings
- Self-management of chronic conditions

III. Cultural Competence
- Care provided at NACA must be culturally responsive and respectful of patient beliefs, traditions, and values.

IV. Language Access
- Interpreter services are provided to patients with limited English proficiency.
- Educational materials are provided in an understandable format.

V. Access to Care
- Same-day or urgent appointments are offered as clinically appropriate.
- After-hours guidance is available for established patients.

VI. Patient Feedback
- Patients are encouraged to provide feedback regarding their experience of care.
- Concerns and grievances are addressed in accordance with NACA policy.

VII. Documentation Requirements
- Patient education and engagement activities must be documented in the EHR
- Use of interpreter services must be documented

VIII.Compliance and Monitoring
- Patient satisfaction data is reviewed
- Complaint resolution is monitored
- Access metrics (appointment availability, wait times) are tracked

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| **POLICY: MS 130** | (X) Revision<br>( ) New | Original Issue Date: 03/04/24<br>Revised Date: 03/10/24; 07/12/24<br>Approved by: Board of Directors<br>Approval Date: 03/20/24; 07/17/24; 06/11/25<br>Effective Date: 03/21/24; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |
| **Allergy Assessment** | Author: Medical Staff Committee | |

**I.** **POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to ensure the systematic assessment, documentation, and management of patient allergies in order to promote patient safety and prevent adverse reactions.

**II.** **PURPOSE:** To establish standardized expectations for identifying, documenting, and managing drug and non-drug allergies in the primary care setting.

**III.** **SCOPE:** Applies to all clinical staff responsible for patient intake, assessment, and care delivery.

**IV.** **GOVERNANCE:** All allergy-related procedures and clinical protocols are approved by the Medical Director and reviewed annually.

**V.** **REFERENCES:**

- CDC Clinical Safety Guidance
- AAAHC Patient Safety Standards

**MS130A ALLERGY ASSESSMENT PROCEDURE**

1. Initial Allergy Screening
    - All patients shall be asked about drug and non-drug allergies at:
    - Initial visit
    - Annual visits
    - Subsequent visits when clinically indicated

2. Allergy History Collection:  Staff will document:
    - Allergen (medication, food, environmental, etc.)
    - Type of reaction
    - Severity of reaction
    - Approximate date or history (if known)

3. EHR Documentation
    - All allergies must be entered into the Electronic Health Record (EHR).
    - Allergies must be reconciled and verified:
    - At every patient visit
    - Prior to prescribing or administering medications

4. Clinical Review: Providers review documented allergies before:
    - Prescribing medications
    - Administering treatments
    - Performing procedures

5. Patient Education Patients with identified allergies will receive education regarding:
    - Allergen avoidance
    - Recognition of symptoms
    - Emergency response (if applicable)

Documentation Requirements
- All allergies must be documented in the EHR
- Allergy reconciliation must be recorded at each visit
- Any updates or corrections must be clearly documented

Compliance and Monitoring
- Chart audits for allergy documentation and reconciliation
- Monitoring of medication safety events
- Annual review of allergy documentation compliance

**MS130B ALLERGY AND ANAPHYLAXIS CLINICAL PROTOCOL**

**I. PURPOSE:** To provide standardized criteria for identifying severe allergic reactions and initiating appropriate emergency response.

**II. ANAPHYLAXIS CRITERIA**

**➞ Suspect anaphylaxis if ANY of the following occur rapidly after exposure:**

- Airway involvement:
  - Difficulty breathing
  - Wheezing or stridor
  - Swelling of tongue, lips, or throat
- Cardiovascular symptoms:
  - Hypotension
  - Dizziness or syncope
- Skin/mucosal involvement:
  - Hives (urticaria)
  - Itching
  - Flushing
  - Swelling
- Gastrointestinal symptoms:
  - Vomiting
  - Diarrhea
  - Abdominal cramping

**III. EMERGENCY RESPONSE (REQUIRED ACTIONS)**

**➞ Immediate intervention is required:**

- Administer Epinephrine immediately (if available and within scope)
  - Preferred route: intramuscular (IM)
  - Location: lateral thigh
- Activate Emergency Medical Services (Call 911)

Position patient:

  - Supine with legs elevated (if tolerated)
  - Recovery position if vomiting or unconscious
- Administer supplemental oxygen if available

Monitor:

  - Airway
  - Breathing
  - Circulation
- Repeat epinephrine per protocol and scope if symptoms persist

**IV. POST-RESPONSE ACTIONS**

  - Document all interventions in the EHR
  - Notify provider immediately
  - Ensure transfer to higher level of care

## V. SCOPE AND AUTHORITY

- This protocol is approved by the Medical Director of NACA
- Staff must act within their scope of practice
- Standing orders may authorize administration of epinephrine by trained staff

## VI. DOCUMENTATION REQUIREMENTS

- Reaction description
- Time of onset
- Interventions performed
- Time epinephrine administered
- EMS activation time
- Outcome

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| **POLICY: MS 200** | (X) Revision<br>( ) New | Original Issue Date: 02/20/06<br>Revised Date: 09/03/20; 07/12/24<br>Approved by: Board of Directors<br>Approval Date: 09/16/20; 07/17/24; 06/11/25<br><br>Effective Date: 09/17/20; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |
| **Clinical Practice Guidelines and Professional Scopes of Practice** | Author: Medical Staff Committee | |

**I. POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) that all clinical care is delivered in accordance with evidence-based standards, clearly defined scopes of practice, and approved clinical governance structures. The organization maintains accountability for quality, safety, and consistency of care across all services.

**II. PURPOSE:** To establish a comprehensive governance framework that standardizes clinical practice, ensures patient safety, and supports continuous quality improvement across all care delivery activities.

**III. SCOPE:** This policy applies to all licensed providers, nursing staff, medical assistants, and clinical support personnel involved in patient care at NACA.

- All clinical care delivered at NACA shall be aligned with:
  - Indian Health Services (IHS) clinical guidelines and standards of care
  - Uniform Data System (UDS) quality reporting requirements
  - Government Performance and Results Act (GPRA) quality requirements
  - These standards guide performance measurement, population health management, and continuous quality improvement activities.

**IV. GOVERNANCE STRUCTURE:** The Medical Director retains ultimate authority and accountability for:

- Approval of clinical guidelines, protocols, and standing orders
- Oversight of clinical quality and patient safety
- Credentialing and privileging of clinical staff
- Clinical supervision and consultation
- Leadership of quality improvement and peer review activities
- The Medical Director shall be available for clinical consultation within established timeframes to support safe patient care.

- Clinical Staff Responsibilities: All clinical staff must practice within:
  - State licensure requirements
  - Credentialing and privileging status
  - NACA-defined competencies
  - Approved policies, procedures, protocols, and standing orders

**V. APPROVAL AND OVERSIGHT HIERARCHY:** The following clinical governance components require formal

approval and oversight:

1. Clinical Policies
    - Approved by the Medical Director and governing body
    - Reviewed annually
2. Clinical Protocols (e.g., MS 310A, MS 320A)
    - Approved by the Medical Director
    - Must be evidence-based and reviewed annually
3. Standing Orders
    - Approved and signed by the Medical Director
    - Define authorized actions for nursing and support staff
    - Reviewed and reauthorized annually
4. Procedures (Operational Workflows)
    - Approved by clinical leadership
    - Must align with established policies and protocols

**VI. CLINICAL PRACTICE STANDARDS:**

- All care must be based on approved evidence-based clinical guidelines.
    - Clinical decisions must be individualized to patient needs.
    - Deviations from clinical guidelines must be:
    - Clinically justified
    - Clearly documented in the EHR
    - All care must reflect:
    - Patient safety principles
    - Cultural competence
    - Evidence-based practice

**VII. DELEGATION AND SUPERVISION:**

- Clinical tasks may be delegated based on:
    - Scope of practice
    - Verified competency
    - Approved standing orders or protocols

    - Supervising providers remain accountable for:
    - Clinical appropriateness of care
    - Patient outcomes
    - Oversight of delegated tasks

**VIII. DOCUMENTATION AND COMPLIANCE:**

    - All clinical actions must be documented in the Electronic Health Record (EHR)
    - Use of protocols and standing orders must be clearly identified in documentation
    - Provider authentication is required where applicable
- Compliance is monitored through:
    - Chart audits
    - Peer review processes
    - Quality improvement initiatives

- UDS/GPRA performance tracking

**IX. SUPPORTING POLICIES:** This policy governs and supports:

- MS 220 – Advanced Practice Provider Guidelines
- MS 225 – Nursing Clinical Practices
- MS 230 – Medical Assistant Clinical Support
- All clinical protocols and standing orders (e.g., MS 310, MS 320)

**X. REFERENCES:**

- Accreditation Association for Ambulatory Health Care (AAAHC) Standards
- Indian Health Service (IHS) Clinical Guidelines
- Health Resources and Services Administration (HRSA) Uniform Data System (UDS)
- Government Performance and Results Act (GPRA)

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| **POLICY: MS 220** | (X) Revision<br>( ) New | Original Issue Date: 11/09/05<br>Revised Date: 09/03/20; 07/12/24; 06/02/25 |
| **Clinical Practice Guidelines for Advanced Practice Providers** | Author: Medical Staff Committee | Approved by: Board of Directors<br>Approval Date: 09/16/20; 07/17/24; 06/11/25<br>Effective Date: 09/17/20; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |

**I.** **POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to ensure that Advanced Practice Providers (APPs), including Nurse Practitioners and Physician Assistants, deliver care within their licensure, credentialing, and privileging, consistent with MS 200 Clinical Governance.

**II.** **PURPOSE**: To define the scope, responsibilities, and expectations for APPs to ensure safe, effective, and consistent clinical care.

**III.** **SCOPE: Applies** to all Nurse Practitioners and Physician Assistants providing care at NACA.

**IV.** **GOVERNANCE:** All APP practice is subject to oversight by the Medical Director in accordance with MS 200.

**V.** **SCOPE OF PRACTICE:**

- Diagnose and treat medical conditions
- Prescribe medications and therapies
- Order and interpret diagnostic tests
- Coordinate referrals and follow up care

**VI.** **CLINICAL STANDARDS**

- Providers shall use utilized approved care practice guidelines and approved clinical protocols.
- Evidence-based guidelines
- Clinical Decisions must reflect patient-specific risk assessment and be clearly documented in the electronic health record.

**VII.** **CONSULTATION AND ESCALATION**

- Providers shall seek consultation from the medical director when:
  - Clinical presentation exceeds scope or experience
  - Patient condition is unstable or high risk
  - Diagnostic uncertainty exists

**VIII.** **HIGH RISK CARE**

- Providers shall:

- Perform risk assessment prior to procedures
- Escalate care appropriately
- Transfer patients when higher level care is required

## IX. STANDING ORDERS AND PROTOCOL USE:

- APPs may utilize Medical Director Approved protocols and standing orders
- All use must be documented in the EHR.

## X. DOCUMENTATION:

- All encounters, decisions, and consultations must be recorded in the electronic health record.
- Deviations from guidelines must include rationale

## XI. COMPLIANCE AND MONITORING:

- Chart Audits and Peer Review
- Credentialing and Privileging Review
- Compliance with UDS/GPRA quality measures

## XII. REFERENCES

- MS 200 Clinical Governance Policy
- AAAHC Standards
- IHS Clinical Guidelines

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| **POLICY: MS 225** | (X) Revision<br>( ) New | Original Issue Date: 11/09/05<br>Revised Date: 09/03/20; 07/12/24; 11/11/24 |
| **Clinical Practice Guidelines for Nurses (RNs)** | Author: Medical Staff Committee | Approved by: Board of Directors<br>Approval Date: 09/16/20; 07/17/24; 11/20/24; 06/11/25<br>Effective Date: 09/17/20; 07/18/24; 12/02/24; 06/12/25<br>Annual Review Date: 06/11/25 |

**I. POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) that Registered Nurses (RNs) provide care in accordance with provider direction, approved protocols, and standing orders, consistent with MS 200 Clinical Governance.

**II. PURPOSE**: To define the clinical role, responsibilities, and authority of nursing staff in patient care delivery.

**III. SCOPE:** Applies to all Registered Nurses providing clinical services at NACA.

**IV. GOVERNANCE:** Nursing practice is overseen by the Medical Director and must align with MS 200 requirements.

**V. CORE RESPONSIBILITIES:** RNs are responsible for:

- Patient assessment and monitoring
- Medication administration
- Immunizations per standing orders
- Care coordination and follow-up
- Patient education

**VI. CLINICAL PRACTICE REQUIREMENTS:** - All nursing care must follow:

- Medical Director-approved protocols
- Standing orders
- Provider direction

**VII. STANDING ORDERS AND PROTOCOL USE:** RNs are authorized to:

- Initiate care under standing orders when criteria are met
- Implement clinical protocols
- Perform delegated tasks within scope

**VIII. ESCALATION REQUIREMENTS:** RNs must immediately notify a Provider for:

- Abnormal findings
- Patient deterioration
- Critical symptoms or values

**IX. DOCUMENTATION REQUIREMENTS:**

- All assessments, interventions, and communications must be documented in the EHR
- Protocol or standing order use must be identified

## X. COMPLIANCE AND MONITORING:

- Chart audits
- Nursing competency validation
- Quality improvement tracking (UDS/GPRA)

## XI. REFERENCES:

- MS 200 Clinical Governance Policy
- AAAHC Standards
- CDC Clinical Guidance

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| **POLICY: MS 230** | (X) Revision<br>( ) New | Original Issue Date: 11/09/05<br>Revised Date: 09/03/20; 07/12/24; 06/02/25 |
| **Clinical Practices Guidelines for Medical Assistants** | Author: Medical Staff Committee | Approved by: Board of Directors<br>Approval Date: 09/16/20; 07/17/24; 06/11/25<br>Effective Date: 09/17/20; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |

**I. POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) that Medical Assistants (MAs) perform clinical support functions under the supervision of licensed providers and nursing staff, consistent with MS 200 Clinical Governance.

**II. PURPOSE:** To define the scope and standardized responsibilities of Medical Assistants in supporting safe and efficient patient care. SCOPE: Applies to all Medical Assistants working in clinical settings at NACA.

**III. GOVERNANCE:** MA duties are delegated by licensed providers and overseen under the authority of the Medical Director.

**IV. CORE FUNCTIONS**: Medical Assistants are responsible for:

- Obtaining vital signs and patient history
- Performing screenings (depression, tobacco, etc.)
- Assisting with exams and procedures
- Maintaining clinical environments

**V. AUTHORIZED TASKS:** Medical Assistants may:

- Administer medications and immunizations under Provider order and approved standing orders
- Perform CLIA-waived testing
- Collect and process specimens

**VI. CLINICAL PRACTICE REQUIREMENTS:** - All tasks must be performed according to:

- Approved protocols
- Standing orders
- Delegation by licensed staff

**VII. ESCALATION REQUIREMENTS**: MAs must immediately notify a Provider or RN for:

- Abnormal vital signs
- Chest pain or respiratory distress
- Significant bleeding or injury
- Blood glucose <70 or >300
- Oxygen saturation < 90%
- Any ill-appearing patient

**VIII. LIMITATIONS:** - MAs may not independently diagnose, interpret clinical data, or make treatment decisions

**IX. DOCUMENTATION REQUIREMENTS:**

- All tasks, screenings, and results must be documented in the EHR
- Delegated tasks must be identifiable in documentation

**X. COMPLIANCE AND MONITORING:**

- Competency validation
- Chart audits
- Supervision review

**XI. REFERENCES:** - MS 200 Clinical Governance Policy - AAAHC Standards - CDC Infection Control Guidelines

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| **POLICY: MS 300** | (X) Revision<br>( ) New | Original Issue Date: 11/09/05<br>Revised Date: 09/03/20; 07/12/24; 11/11/24 |
| **Preventive Care Guidelines for Adult Patients (18 – 65+ years)** | Author: Medical Staff Committee | Approved by: Board of Directors<br>Approval Date: 09/16/20; 07/17/24; 11/20/24; 06/11/25<br>Effective Date: 09/17/20; 07/18/24; 12/02/24; 06/12/25<br>Annual Review Date: 06/11/25 |

**I. POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to provide evidence-based preventive care services that promote early detection, disease prevention, and overall population health improvement.

**II. PURPOSE:** To establish standardized expectations for preventive screenings, immunizations, and health maintenance services.

**III. SCOPE**: Applies to all clinical staff involved in preventive care delivery at NACA.

**IV. GOVERNANCE**: Preventive care protocols and standing orders are approved by the Medical Director and reviewed annually in accordance with MS 200.

**V. STANDARDS**:

- Care aligns with USPSTF recommendations
- Immunizations follow CDC schedules
- Preventive services support UDS/GPRA measures
- Care is culturally responsive and patient-centered

**VI. REFERENCES:**

- USPSTF Guidelines
- CDC Immunization Schedule
- HRSA/UDS Measures
- IHS Preventive Health Guidance

**MS300A PREVENTIVE CARE PROCEDURE**

1. Patient Assessment
    - Preventive care needs are assessed at each visit based on age, risk, and history.

2. Screening and Immunization Review
    - Staff identify care gaps using EHR tools and preventive care guidelines.

3. Service Delivery
    - Preventive services may include:
    - Vital signs and health screenings
    - Immunizations
    - Health counseling and education

4. Referrals
    - Patients are referred for additional testing or specialty care as needed.

5. Patient Education
    - Patients are counseled regarding preventive health, screenings, and lifestyle factors.

6. Documentation Requirements
    - Preventive services and education must be documented in the EHR
    - Care gaps addressed or deferred must be recorded

7. Compliance and Monitoring
    - UDS/GPRA preventive metrics monitored
    - Chart audits for screening compliance
    - Population health tracking via registries

**MS300B PREVENTIVE CARE PROTOCOL**

**I. PURPOSE:** To standardize preventive care delivery based on patient age, risk, and evidence-based guidelines.

**II. SCREENING CRITERIA:** Preventive screening shall be conducted according to:

- USPSTF recommendations
- Patient-specific risk factors

**III. IMMUNIZATION PROTOCOL**

- Immunizations follow CDC schedules by age group
- Contraindications must be reviewed prior to administration

**IV. CARE GAP IDENTIFICATION**

- Patients with overdue screenings or immunizations must be flagged in the EHR
- Standing orders may be used to initiate services

**V. ESCALATION**

- Abnormal screening results must be reviewed by a Provider
- Follow-up actions must be initiated and documented

**VI. AUTHORITY**

Protocol approved by the Medical Director
Standing orders authorize staff to implement preventive services within scope

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| **POLICY: MS 310** | (X) Revision<br>( ) New | Original Issue Date: 02/15/05<br>Revised Date: 05/02/19; 07/12/24; 06/02/25 |
| **Clinical Care Guidelines for Adult Patients with Hypertension** | Author: Medical Staff Committee | Approved by: Board of Directors<br>Approval Date: 05/22/19; 07/17/24; 06/11/25<br>Effective Date: 05/23/19; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |

**I. POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to provide evidence-based, patient-centered care for hypertension in accordance with Medical Director–approved protocols and national clinical guidelines. All clinical management is governed by MS 200 and operationalized through MS 310A (Clinical Protocol).

**II. PURPOSE:** The purpose of this policy is to ensure consistent, high-quality hypertension management in adult patients in order to reduce cardiovascular morbidity and mortality through early detection, appropriate evaluation, effective treatment, and ongoing monitoring.

## III. AUTHORITY AND RESPONSIBILITIES:

- Medical Providers are responsible for diagnosing hypertension, developing and managing treatment plans, prescribing medications, and ensuring appropriate follow-up.
- Qualified Support Personnel (RNs, MAs, Health Technicians, Health Educators, Community Health Representatives) may assist in care delivery, patient education, monitoring, and implementation of standing orders as authorized by medical providers and separate standing order policies.
- Clinical care shall be delivered in accordance with approved NACA hypertension protocols

D. Patients with hypertension shall be managed according to approved hypertension protocols aligned with national guidelines.

E. All assessment, treatment, monitoring, and referral processes are defined in MS 310A.

## IV. STANDARDS AND REFERENCES

- American Academy of Family Physicians (AAFP)
- AAAHC
- UDS
- GPRA

## V. RELATED DOCUMENTS

- MS310-A Hypertension Care Protocol
- Preventive Care Protocol for Adult Patients (MS 300)

**MS 310-A – Hypertension Care Protocol**

## I. RATIONALE

Uncontrolled hypertension is a major risk factor for stroke, myocardial infarction, heart failure, and kidney disease. A standardized approach supports early control, medication adherence, and risk reduction.

## II. INITIAL ASSESSMENT (New Patients and Annually Thereafter)

A. History and Risk Assessment
- Mental Status Assessment
- Smoking status
- History of Diabetes mellitus
- History of Cardiovascular disease or chronic kidney disease
- Family history of cardiovascular disease
- Lifestyle factors (diet, physical activity, alcohol use)
- Female > 45 years of age
- Male > 35 years of age
- Pregnancy Potential
- Fall Risk Assessment

B. Review of Systems
- Neurological (dizziness, headaches, syncope)
- Cardiovascular (chest pain (especially with activity), palpitations, lower extremity edema)
- Respiratory (shortness of breath, dyspnea on exertion)
- Genitourinary (frequency, retention, incontinence, or changes)
- Constitutional (fatigue)

C. Medication Review and Reconciliation

D. Blood Pressure Measurement
- Patient seated with feet flat on the floor and arm supported at heart level
- Appropriate cuff size used
- Repeat BP after 5 minutes if initial reading is elevated

E. Physical Examination
- Height and weight
- Heart and lung examination
- Carotid pulses
- Fundoscopic exam or referral as indicated

F. Documentation
- All findings recorded in the electronic health record (EHR)

## III. LABORATORY EVALUATION

Order and review the following based on clinical indication:
- Serum creatinine (comprehensive metabolic profile)
- Serum potassium (comprehensive metabolic profile)
- Serum glucose or A1c (comprehensive metabolic profile)
- Lipid profile
- Urinalysis and/or urine microalbumin

## IV. LIFESTYLE AND PREVENTION COUNSELING

- Provide education and referrals as appropriate:
  - Weight loss counseling
  - Alcohol Use
  - Physical activity
  - Tobacco cessation
  - Stress Reduction
  - Dietary counseling (consider sodium/saturated fat/cholesterol intake)
  - Referral to Dietitian
  - Referral to Wellness Center

## V. TREATMENT TARGETS

Blood Pressure Goals

- Age ≥60 years: Treat to SBP <140 mmHg and DBP <90 mmHg
- Age <60 years, diabetes, or CKD: Treat to SBP <140 mmHg and DBP <90 mmHg

## VI. PHARMACOLOGIC MANAGEMENT

Initial Therapy Selection

- Non-African American patients: thiazide diuretic, CCB, ACE-I, or ARB
- African American patients: thiazide diuretic or CCB
- CKD (any race): ACE-I or ARB unless contraindicated

Special Considerations

- ACE-I and ARBs are contraindicated in pregnancy
- Do not use ACE-I and ARB together
- Consider beta blocker for persistent increased heart rate and/or chronic chest pain (angina)

ACE/ARB and Diuretic Combination

- Exclusion Criteria
  - Renal Insufficiency
  - Congestive Heart Failure (CHF)
  - Volume Depletion (diuretics, dialysis, gastrointestinal disease)
  - History of angioedema or allergic reaction with ACE-I or ARB
  - Allergic reaction to thiazides
  - Hepatic Dysfunction: ALT greater than 3 times the upper limit of reference ranger in the prior 3 months
  - Renal Artery Stenosis
  - Aortic Stenosis/hypertrophic cardiomyopathy
  - Active or history of gout
  - Baseline serum creatinine greater than 2.5mg/dL
  - Baseline serum potassium greater than 5.0mmol/L
  - Serum Sodium less than or equal to 130 mmol/L
  - Current Lithium therapy

- Discontinuation of ACE-I and ARB
    - Angioedema
    - ACE-I induced cough
    - Elevation of serum creatinine to greater than 3mg/dL
    - Elevation of serum potassium to greater than 6.0mmol/L
- Discontinuation of Thiazide/Diuretics
    - Allergic reaction or intolerance
    - Development of gout or uric acid renal stones
    - Electrolyte Imbalance (sodium, potassium)

ACE-INHIBITORS AND ARB

- Exclusion Criteria
    - History of angioedema related to ACE-I or ARB
    - Pregnancy, planning pregnancy, or breastfeeding
    - Known renal artery stenosis
    - Aortic stenosis or hypertrophic cardiomyopathy
    - Hepatic dysfunction (ALT >3× upper limit of normal in past 3 months)
    - Baseline serum creatinine >2.5 mg/dL
    - Baseline serum potassium ≥5.0 mmol/L
    - Current lithium therapy
- Discontinue NSAID if taking regularly
- Monitoring:
    - Baseline: Serum creatinine, potassium, and blood pressure within 6 months prior to initiation
    - Follow-up: Serum creatinine and potassium within 1–2 weeks after initiation or dose change
    - Review for concurrent NSAID use and discontinue when clinically appropriate

THIAZIDE DIURETIC

- Exclusion Criteria
    - Allergy or intolerance to thiazides
    - Pregnancy or breastfeeding
    - Hepatic dysfunction (ALT >3× ULN)
    - Active or prior gout
    - Baseline creatinine >2.5 mg/dL
    - Concurrent spironolactone or lithium therapy
    - Serum sodium ≤130 mmol/L
    - Serum potassium ≤3.4 mmol/L

- Medication and Dosing
    - Chlorthalidone:
        - Initiation: 12.5 mg once daily
        - Maximum: 25 mg once daily
    - Hydrochlorothiazide:
        - Initiation: 12.5 mg once daily
        - Maximum: 25 mg once daily

- Monitoring
    - Baseline: Sodium, potassium, creatinine within 6 months
    - Follow-up: Repeat labs 1–2 weeks after initiation or dose change

CALCIUM CHANNEL BLOCKER (CCB)

- Exclusion Criteria
    - Allergy or intolerance to CCBs
    - Pregnancy or breastfeeding
    - Hepatic dysfunction (ALT >3× ULN)
    - Heart failure with EF <40%
    - Aortic stenosis or hypertrophic obstructive cardiomyopathy
    - Significant heart block
    - Bradycardia (for non-dihydropyridine agents)

- Medication and Dosing:
    - Amlodipine: Initiate 2.5 mg daily; max 10 mg daily
    - Nifedipine ER: Initiate 30 mg daily; max 90 mg daily
    - Diltiazem ER:
    - Use only if HR >60 bpm and not on beta blocker
    - Initiate 120 mg daily; max 360 mg daily

- Monitoring:
    - Assess for peripheral edema
    - Monitor heart rate with non-dihydropyridine agents

BETA BLOCKER

- Exclusion Criteria:
    - Allergy or intolerance to beta blockers
    - Pregnancy or breastfeeding
    - Bradycardia (HR <60 bpm)
    - Heart block
    - Severe asthma or COPD (use caution)
    - Concurrent verapamil or diltiazem therapy

- Medication and Dosing:
    - Atenolol: Initiate 25 mg daily; max 100 mg daily
    - Metoprolol: Initiate 25 mg daily; max 100 mg daily
    - Carvedilol: Initiate 12.5 mg daily; max 50 mg daily
    - Propranolol: Initiate 80 mg daily; max 240 mg daily

- Monitoring:
    - Monitor heart rate and blood pressure
    - Assess for fatigue, dizziness, or signs of intolerance

Ongoing Monitoring and Follow-Up

1. Home Blood Pressure Monitoring
    - Morning measurement after voiding and before caffeine
    - Patient to bring or transmit readings at follow-up visits
2. Laboratory Monitoring
    - Serum chemistry within 1–2 weeks of medication changes
    - Routine labs every 6 months once stable
3. Follow-Up Frequency
    - Controlled BP: every 3–6 months
    - Uncontrolled BP: every 4–6 weeks until at goal

**VII. MEDICATION TITRATION AND FOLLOW-UP**

- Reassess BP within one month of initiation or dose adjustment
- Increase dose or add a second agent if BP goal not achieved
- Add a third agent if uncontrolled on two medications
- Consider referral to a hypertension specialist if BP remains uncontrolled

**VIII. PATIENT ENGAGEMENT AND ADHERENCE**

- Educate patient and family regarding hypertension
- Encourage hypertension treatment adherence
- Encourage home BP monitoring
- Simplify medication regimens when possible
- Anticipate and manage side effects proactively
- Reinforce positive progress toward goals

**IX. REFERRALS AND ADDITIONAL SUPPORT**

- Health Promotion
- Dietitian
- Wellness Center
- Specialty referral as clinically indicated

**X. RELATED PROTOCOLS AND STANDING ORDERS**

- Preventive Care Protocol for Adult Patients (MS 300)
- Collect urine sample and order urine microalbumin if 12 months are greater since last result
- Order annual Complete Blood Count, Comprehensive Metabolic Panel, Lipid Panel, Thyroid Stimulating Hormone, C-Reactive Protein, and Hemoglobin A1C.
- Remind patients to bring home BP readings with them to visit

| **Hypertension** | **<140/90** | **>140/90** | **>160/100** |
|---|---|---|---|
| **Appointments** | Every 3 months | Monthly | Weekly |
| **Lab: urine microalbumin, serum chemistry, serum A1C** | Minimum every 12 months | | |
| **Refills** | 90 days | 30 days | 30 days |

| | | |
|---|---|---|
| **POLICY: MS 320** | (X) Revision<br>( ) New | Original Issue Date: 02/15/05<br>Revised Date: 09/03/20; 07/12/24; 06/02/25 |
| **Clinical Care Guidelines for Patients with Diabetes** | Author: Medical Staff Committee | Approved by: Board of Directors<br>Approval Date: 09/16/20; 07/17/24; 06/11/25<br>Effective Date: 09/17/20; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |

**I. POLICY:** The policy of NACA is to provide safe, effective, and patient-centered care for adult patients with diabetes by adhering to current evidence-based standards of practice, applicable federal guidelines (CDC, IHS), and accreditation requirements (AAAHC).

**II. PURPOSE:** To establish organizational expectations for diabetes screening, monitoring, and coordination of care while enabling qualified support personnel to assist licensed providers under standing orders.

**III. GUIDING PRINCIPLES**

- Care is evidence-based, culturally responsive, and consistent with national standards.
- Chronic disease management emphasizes safety, simplicity, and patient self-management.
- Treatment goals are individualized based on age, comorbidities, functional status, and patient preference.
- All patients with diabetes shall receive routine monitoring and screening for complications including:
    - Glycemic Control
    - Diabetic Foot Examinations
    - Diabetic Retinopathy Screening

**IV. DEFINITIONS:**

Diabetes is a group of metabolic diseases characterized by hyperglycemia resulting in defects in insulin secretion, insulin action, or both.

- Type I Diabetes: Due to autoimmune beta cell destruction, leading to absolute insulin deficiency.
- Type II Diabetes: Progressive loss of beta cell insulin secretion on the background of insulin resistance.
- Diabetes: Diagnosed 2nd or 3rd trimester of pregnancy that was not clearly over diabetes prior to gestation.
- Specific types of diabetes due to other causes: e.g., monogenic diabetes syndromes (neonatal diabetes, maturity onset diabetes of the young), diseases of the exocrine pancreas (cystic fibrosis, pancreatitis), and drug- or chemical-induced diabetes (glucocorticoid use, treatment of HIV/AIDS, organ transplantation).

**V. GENERAL STANDARDS**

- Adult patients with diabetes are monitored at intervals consistent with glycemic control status.
- Support personnel may perform A1c testing, foot exams, and retinopathy screening per protocol.
- Referrals (podiatry, ophthalmology, nutrition) are made based on screening results and clinical need.
- All results are documented in the EHR and reviewed by a licensed provider.

**MS 320A– Diabetes Care Protocol**

**Scope :** This document contains the clinical protocol and standing orders for adult diabetes care. It operationalizes the Diabetes Policy (2026 Review) and is intended for day-to-day clinical use.

## I. Eligibility

- Adult patients (≥18 years) with diagnosed diabetes mellitus.
- Excludes pregnant or breastfeeding patients (managed under obstetric or specialty protocols).

## II. Initial and Ongoing Assessment :

**At New Diagnosis and at Least Annually Thereafter:**

- Medical history and focused physical examination.
- Review of systems (neurologic, cardiovascular, genitourinary, gastrointestinal, mood, sleep).
- Medication reconciliation and adherence review.
- Blood pressure and weight measurement.
- Review of recent laboratories (CMP, A1c, lipid panel, urine microalbumin; additional labs as clinically indicated).
- Fall risk and brief cognitive screen for older adults.

## III. Glycemic Monitoring

- A1c ≤ 7% and stable: at least every 6 months.
- A1c above 7% or therapy recently changed: every 3 months.
- A1c persistently >8.5%: monthly follow-up until improvement demonstrated.
- Point-of-care A1c may be performed per clinic workflow.

## IV. Treatment Targets

- Glycemic targets are individualized based on age, comorbidities, risk of hypoglycemia, and patient preference.
    - Most non-pregnant adults: A1c <7–8%.
    - Older adults or those with significant comorbidity or limited life expectancy: A1c <8%.
- Blood pressure and lipid targets managed per relevant clinical protocols.

## V. Pharmacologic Management (General Principles)

- Start with lifestyle modification and first-line pharmacotherapy unless contraindicated.
- Optimize dose of one medication before adding another when feasible.
- Prioritize non-insulin therapies
- Insulin therapy may be initiated when clinically indicated based on patient condition and provider judgment
- Begin SGLT2 inhibitor (Jardiance, Invokana, Farxiga, Steglatro) unless contraindicated
    - Contraindications: eGFR<30ml/min, breastfeeding, pregnancy, recurrent genitourinary infections, or history of hypersensitivity to SGLT2 inhibitors.
    - Side Effects:
        - Genital Mycotic Infections
        - Urinary Tract Infections

        - Increased urination / polyuria
        - Incrased risk of ketoacdidosis
    - Medication and Dosing
        - Jardiance: 10 mg daily, Maximum 25 mg daily
        - Invokana: 100 mg daily, Maximum 300 mg daily
        - Farxiga: 5 mg daily, Maximum 10 mg daily
        - Stegaltro: 5 mg daily, Maximum 15 mg daily
- Consider GLP1 (Byetta, Bydureon BCise, Victoza, Trulicity, Ozempic, Wegovy, Adlyxin, Rybelsus, Saxenda) particularly in older patients.
    - Side Effects
        - Nausea/Vomiting
        - Diarrhea/Constipation
        - Abdominal Pain/Cramping
        - Dyspepsia/Bloating
        - Early Satiety/Decreased Appetite
        - Increased Risk of Pancreatitis
    - Medication and Dosing
        - Byetta: 5 mcg subcutaneous twice daily; Maximum 10 mcg subcutaneous twice daily
        - Bydureon BCise : 2 mg subcutaneous once weekly, 2 mg subcutaneous once weekly
        - Victoza: 0.6 mg subcutaneous once daily (initiation), 1.2 mg subcutaneous once daily (therapeutic), Maximum 1.8 mg subcutaneous once daily
        - Trulicity: 0.75 mg subcutaneous once weekly (initiation), 1.5 mg → 3 mg → 4.5 mg subcutaneous once weekly, Maximum 4.5 subcutaneous once weekly
        - Ozempic: 0.25 mg subcutaneous once weekly (non-therapeutic, for GI tolerability) , Usual doses: 0.5 mg or 1 mg subcutaneous once weekly, Maximum 2 mg subcutaneous once weekly
        - Wegovy: 0.25 mg subcutaneous once weekly, Increase every 4 weeks (0.5 → 1 → 1.7 mg subcutaneous once weekly) , Maximum 2.4 mg subcutaneous once weekly
        - Adlyxin: 10 mcg SC once daily for 14 days , Maintenance & max dose: 20 mcg SC once daily
        - Rybelsus: Starting dose: 3 mg PO once daily (for tolerability only), Usual dose: 7 mg PO once daily; Maximum 14 mg PO once daily
        - Saxenda: Starting dose: 0.6 mg subcutaneous once daily, Titration: Increase weekly by 0.6 mg subcutaneous once daily, Maximum / target dose: 3.0 mg subcutaneous once daily
- Prefer agents with cardiovascular and renal benefit when clinically appropriate.
- Avoid hypoglycemia-prone regimens when possible.
- Adjust therapy approximately every 4 weeks until goals are met.
- Specialty consultation is recommended when goals are not achieved despite multi-agent therapy or when safety concerns arise.
- Change to 90 day prescription once regimen is determined and goal obtained.
- Must be on ACE/ARB (except women of reproductive age)
- Must be on Statin

**VI. Lifestyle & Self-Management Support**

- Nutrition counseling with emphasis on portion control and carbohydrate quality.
- Physical activity goal: ~30 minutes most days, with adaptive options as needed.
- Smoking cessation support.
- Education on home glucose monitoring, sick-day management, and medication adherence.
- Referrals to nutrition, wellness center, or health education services as indicated.

## VI. Home Glucose Monitoring

- Begin with before each meal and at bedtime
- Record readings and bring to next office visit
- May decrease number of times per day to daily as diabetes becomes controlled

## VII. Screening & Preventive Care

- Foot examination: at least annually and at each visit if abnormalities present.
- Retinopathy screening: at least annually via fundus photography or ophthalmology referral.
- Nephropathy screening: urine microalbumin at least annually.
- Ensure age-appropriate vaccinations and cancer screenings per separate protocols.

## VIII. Standing Orders for Support Personnel (See MS320B Diabetes Care Standing Orders)

Authorized nursing support personnel and health educators may:

- Perform and document point-of-care A1c testing per monitoring schedule.
- Perform diabetic foot examinations and document findings.
- Perform or coordinate diabetic retinopathy screening.
- Order routine labs (A1c, urine microalbumin, CMP) when due per protocol.
- Ensure patients remove shoes and socks at diabetes visits.
- Schedule follow-up appointments based on glycemic control status.
- All results must be reviewed and acknowledged by a licensed provider.

## IX. Documentation & Follow-Up

- All assessments, results, and patient education are documented in the EHR.
- Home glucose or A1c trends are reviewed at each visit.
- Follow-up intervals are determined by current control status and recent therapy changes.

## X. Quality & Safety

- This protocol is reviewed annually and updated to reflect changes in national guidelines and accreditation standards.

**MS 320B– Diabetes Care Standing Orders**

**Purpose**: To operationalize the Clinical Care Guidelines for Patients with Diabetes (MS 320) and the Diabetes Care Protocol (MS 320A) by authorizing qualified support personnel to perform routine preventive foot, eye, and glycemic monitoring activities for adult patients with diabetes, ensuring timely screening, referrals, and patient education.

**Scope & Eligibility**

- Population: Adult patients (≥18 years) with a diagnosis of diabetes mellitus.
- Exclusions: Pregnant or breastfeeding patients (managed under obstetric/specialty protocols).
- Applies To: Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Medical Assistants (MAs), Health Educators, and Community Health Representatives acting under standing orders.

**Authorized Standing Orders**

Qualified support personnel are authorized to initiate and complete the following without a direct provider order, with subsequent provider review and authentication in the EHR.

1**. Hemoglobin A1C (HbA1c) Monitoring**

- Action: Perform or order point-of-care or laboratory Hemoglobin A1C testing per protocol.
- Frequency:
    - A1C Less than 7% and stable glycemic control: At least every 6 months.
    - A1C greater than 7%, recent medication change, or unstable control: Every 3 months.
    - Persistently poor control (e.g., A1C >8.5%) or per provider direction: May require more frequent follow-up per protocol.
- Documentation: Record results in the EHR and flag abnormal or overdue results for provider review.
- Escalation: Patients overdue for A1C testing or with elevated results must be scheduled for follow-up with a licensed provider per protocol.

2. **Annual Diabetic Foot Examination**

- Action: Instruct patient to remove socks and shoes for examination.
- Frequency: At least annually; at each visit if abnormalities are present.
- Components:
    - Inspection of skin integrity (ulcers, calluses, skin breakdown, infection).
    - Assessment of temperature, color, hair distribution, and nail condition.
    - Palpation of pedal pulses as appropriate.
    - Sensory testing per clinic protocol (e.g., monofilament) if trained.
- Documentation: Record findings in the designated diabetic foot exam section of the EHR.
- Escalation: Notify provider of abnormal findings the same day.

3. **Annual Foot Care Education**

- Action: Provide and document annual foot care education, including:
    - Daily self-inspection of feet.
    - Foot hygiene and skin care.
    - Proper footwear recommendations.

    - Nail trimming education (safe technique, avoidance of cutting cuticles or corners too deeply).

- Referral Option: If the patient is unable to safely trim nails (e.g., vision impairment, limited mobility, neuropathy, thickened nails), initiate a referral for nail trimming (podiatry or approved clinical service) per referral policy.
- Documentation: Record education provided and patient understanding in the EHR.

4. **Annual Podiatry Referral**
    - Action: Initiate annual podiatry referral for patients with diabetes.
    - Indications:
        - Routine preventive diabetic foot care, or
        - Any abnormal findings (e.g., neuropathy, deformity, ulcers, recurrent calluses, nail pathology).

5. **Diabetic Retinopathy Screening (Fundus Photos)**
    - Action: Perform or coordinate diabetic retinopathy screening via fundus photography when available.
    - Frequency: At least annually.
    - Process:
        - Confirm date and results of last retinal exam or fundus photos.
        - Perform fundus photography if due and patient eligible.
        - Ensure images are submitted for interpretation per clinic workflow.
    - Documentation: Upload results to the EHR for provider review and signature.
    - Escalation: Abnormal or unreadable results require ophthalmology referral.

6. **Annual Ophthalmology Referral**
    - Action: Initiate annual ophthalmology referral for a dilated retinal examination.
    - Indications:
        - No documented retinal exam or fundus photos within the last 12 months.
        - Abnormal or inconclusive fundus photography results.
        - New or worsening visual symptoms.

7. **Diagnosis Related Education**
    - **Action:** Under standing orders, qualified support personnel shall initiate and provide **appropriate diagnosis-related education** for adult patients with diabetes.
    - **Timing:**
        - At **new diagnosis** of diabetes mellitus.
        - **Annually** for reinforcement.
        - With **significant changes** in clinical status, treatment plan, or glycemic control (e.g., elevated A1C, initiation or change of medications, new complications).
    - **Education Topics (as appropriate to diagnosis and patient needs):**
        - Overview of diabetes diagnosis and disease process.
        - Importance of glycemic control and interpretation of **A1C results**.
        - Medication purpose, basic dosing principles, and adherence.
        - Nutrition fundamentals and lifestyle modification.
        - Physical activity recommendations and safety considerations.

  - Recognition, prevention, and management of **hypoglycemia and hyperglycemia**.
  - Prevention of diabetes-related complications (eye, foot, kidney, cardiovascular).
  - Sick-day management and when to seek medical care.
- **Referrals:** Initiate referrals to **Diabetes Self-Management Education (DSME), nutrition, wellness, or health promotion services** when indicated per protocol.
- **Documentation:** Document:
  - Education provided and topics covered.
  - Method/materials used.
  - Patient understanding and engagement.
  - Referrals initiated or declined.

**Documentation Requirements**

- All actions taken under these standing orders must be documented in the EHR, including:
  - Dates and results of A1C testing.
  - Foot exam findings and education topics covered.
  - Fundus photography completion and results.
  - Referrals placed (podiatry, nail care, ophthalmology).
  - Patient refusal or barriers, if applicable.
- A licensed provider must review and acknowledge all entries and results.

**Quality & Safety**

- Standing orders are reviewed annually in conjunction with MS 320 and MS 320A updates.
- Compliance is monitored through chart audits and quality improvement activities.

**References**

- MS 320 – Clinical Care Guidelines for Patients with Diabetes
- MS 320A – Diabetes Care Protocol, Education Expectation
- MS 322 – Standing Orders for Adult Patients with Diabetes
- MS 710 – Patient Education
- MS 930 – Referred Care Policy

| Diabetes Type II | A1C < 7% | A1C 7.1- 8.5% | A1C > 8.5% |
|---|---|---|---|
| Appointments | Every 6 months | Every 3 months | Monthly |
| Point of Care A1C | Every 6 months | Every 3 months | Monthly |
| Labs: Urine Microalbumin, CMP, CBC, TSH, CRP, Lipid Panel and Serum A1C | Every 12 months | | |
| Refills | 90 days | 30 days | 30 days |

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| **POLICY: MS 331** | (X) Revision<br>( ) New | Original Issue Date: 05/19/14<br>Revised Date: 09/03/20; 07/12/24; 06/02/25 |
| **Cancer Screening Standing Orders for Adult Patients** | Author: Medical Staff Committee | Approved by: Board of Directors<br>Approval Date: 09/16/20; 07/17/24; 06/11/25<br>Effective Date: 09/17/20; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |

**I. POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to provide evidence-based cancer screening services aligned with nationally recognized guidelines to support early detection and improved outcomes.

**II. PURPOSE** The purpose of this policy is to promote early detection of cancer and reduction of cancer-related morbidity and mortality, standardize preventive cancer screening practices across clinical settings, Distinguish appropriate screening pathways for average-risk versus increased/high-risk patients.

**III. SCOPE:** Applies to all clinical staff involved in preventive and diagnostic care services.

**IV. GOVERNANCE:** All cancer screening protocols and standing orders are approved by the Medical Director and reviewed annually in accordance with MS 200.

**V. REFERENCES**

- UPSTF Guidelines
- HHS Preventive Services
- CDC Cancer Screening Programs
- AAAHC Standards

**MS 331A – CANCER SCREENING PROTOCOL**

## I. RISK ASSESSMENT (ALL CANCERS)

- Prior to assigning a screening schedule, providers shall assess and document:
  - Personal history of cancer or premalignant disease
  - Family history (first- and second-degree relatives; age at diagnosis)
  - Known or suspected hereditary cancer syndromes
  - Prior therapeutic radiation exposure relevant to the organ system
  - Immunocompromised status
  - Race/ethnicity when clinically associated with increased cancer risk
  - Patients meeting high-risk criteria follow modified screening pathways. USPSTF average-risk intervals do not apply to high-risk patients**.**

## II. BREAST CANCER SCREENING

- Average-Risk Criteria
  - No known genetic mutation (e.g., BRCA1/BRCA2)
  - No prior chest radiation therapy
  - No personal history of breast cancer or high-risk lesions
  - Average-Risk Screening
    1. Ages 40–74: Screening mammography every 1 year
    2. Ages 55 + : Screening mammography every 1 year unless patient chooses every 2 years
    3. Age ≥75: Individualized decision-making
- High-Risk Factors
  - First-degree relative with breast or ovarian cancer
  - Known or suspected hereditary breast cancer mutation
  - Prior chest radiation (especially before age 30)
  - Personal history of ADH, ALH, or LCIS
  - High-Risk Screening
    1. Begin screening earlier than age 40
    2. Annual mammography typically indicated
    3. Adjunct breast MRI as clinically indicated
    4. Genetics or specialty referral recommended

## III. COLORECTAL CANCER SCREENING

- Average-Risk Criteria
  - No personal or strong family history of colorectal cancer
  - No hereditary colorectal cancer syndrome
  - No inflammatory bowel disease
- Average-Risk Screening
  - Ages 45–75: Routine screening using any approved modality
  - Ages 76–85: Selective screening based on health status and prior screening history
- Approved Modalities:

    - FIT or high-sensitivity FOBT – annually
    - Stool DNA-FIT – every 1–3 years
    - CT colonography – every 5 years
    - Flexible sigmoidoscopy – every 5 years (or 10 years with annual FIT)
    - Colonoscopy – every 10 years
- High-Risk Factors
    - First-degree relative with colorectal cancer or advanced adenoma
    - Known hereditary syndromes (e.g., Lynch syndrome, FAP)
    - Personal history of colorectal cancer or adenomatous polyps
    - Inflammatory bowel disease
- High-Risk Screening
    - Begin screening before age 45 (often age 40 or earlier)
    - Colonoscopy preferred
    - Shortened screening intervals (e.g., every 1–5 years)
    - Gastroenterology management required

## IV. CERVICAL CANCER SCREENING

- Average-Risk Criteria
    - No history of CIN2+, cervical cancer
    - Not immunocompromised
- Average-Risk Screening
    - Ages 21–29: Cytology every 3 years
    - Ages 30–65: Preferred: High-risk HPV testing every 5 years (clinician- or patient-collected) Acceptable: Cotesting every 5 years or cytology alone every 3 years
    - <21 (not sexually active) or >65 (with adequate prior screening): No screening
- Post-hysterectomy (no cervix, no CIN2+): No screening
- High-Risk Factors
    - Prior CIN2/3 or cervical cancer
    - Immunocompromised state (e.g., HIV)
- High-Risk Screening
    - More frequent screening required
    - Screening may continue beyond age 65
    - Follow disease-specific surveillance guidance

## V. PROSTATE CANCER SCREENING

- Average-Risk Criteria
    - No family history of prostate cancer
    - No known hereditary prostate cancer mutation
- Average-Risk Screening
    - Ages 55–69: PSA-based screening via shared decision-making
    - Age ≥70: Routine screening not recommended
- High-Risk Factors
    - First-degree relative with prostate cancer (especially <65)
    - Multiple affected family members

- African ancestry
- Known genetic mutations (e.g., BRCA1/BRCA2)

- High-Risk Screening
  - Begin shared decision-making earlier (ages 40–54)
  - PSA interval individualized (often every 1–2 years if chosen)

## VI. HEPATITIS C (HCV) SCREENING (LIVER CANCER PREVENTION)

- Average Risk
  - Ages 18–79: All adults shall receive a one-time universal screening for Hepatitis
- Modality: HCV antibody testing with reflex to HCV RNA if the antibody is reactive. b. Periodic Screening (Increased Risk)
- Providersshall offer periodic (annual or more frequent) testing for patients with ongoing risk factors, including:
  - Current or past injection drug use.
  - Receipt of blood transfusion or organ transplant before 1992.
  - Long-term hemodialysis.
  - Healthcare/public safety workers after needle-stick or mucosal exposure to HCV-positive blood.
  - History of incarceration.
  - Unregulated tattoos or piercings.

## VII. LUNG CANCER SCREENING

- Eligibility Criteria
  - Ages: 50–80 years.
  - History: 20 pack-year commercial tobacco smoking history.
  - Status: Currently smoke or have quit within the past 15 years.
  - Symptomology: Must be asymptomatic (no cough, weight loss, or hemoptysis).
- Screening Modality
  - Low-Dose Computed Tomography (LDCT): Screening shall be performed annually via LDCT. Standard chest X-rays are not an approved screening modality for lung cancer.
- Formal Cessation Referral: For patients who currently use commercial tobacco, providersshall provide a formal referral to a Certified Tobacco Cessation Specialist or a structured, evidence-based cessation program.
- Cultural Consideration (Tobacco Use): For the purpose of screening eligibility, "tobacco use" refers strictly to commercial tobacco products. Use of traditional or ceremonial tobacco shall be documented in the EHR but is excluded from the pack-year calculation for screening eligibility
- **Discontinuation of Screening**
  - Screening shall cease once the patient:
  - Has not smoked for 15 years.
  - Reaches age 81.
  - Develops a health problem that substantially limits life expectancy or the ability/willingness to undergo curative lung surgery.

**IX.STANDING ORDERS AUTHORITY:** Under Medical Director–approved standing orders, the following actions are authorized:

- AUTHORIZED STAFF:
  - Registered Nurses (RNs)
  - Medical Assistants
  - Health Educators
- AUTHORIZED ACTIONS:
  - Identify patients eligible for cancer screening based on protocol criteria
  - Initiate screening orders in the EHR
  - Provide patient education regarding screening purpose and process
  - Facilitate referrals for screening services as appropriate
- CONDITIONS:
  - Patient must meet established screening criteria
  - No contraindications to screening
  - Patient consent must be obtained
- LIMITATIONS:
  - High-risk patients require provider review prior to screening
  - Abnormal results must be reviewed by a provider
  - Staff may not independently interpret diagnostic results
- PROVIDER OVERSIGHT:
  - All standing orders are approved and signed by the Medical Director of Native Americans for Community Action, Inc. (NACA)
  - Orders are reviewed annually
  - Providers are responsible for final interpretation and follow-up care
- DOCUMENTATION:
  - Use of standing orders must be documented in the EHR
  - Screening eligibility, patient consent, and actions taken must be recorded

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| **POLICY: MS 340** | (X) Revision<br>( ) New | Original Issue Date: 02/16/23<br>Revised Date: 02/25/23; 07/12/24; 11/11/24 |
| **Medical Procedures** | Author: Medical Staff Committee | Approved by: Board of Directors<br>Approval Date: 03/28/23; 07/17/24; 11/20/24; 06/11/25<br>Effective Date: 03/29/23; 07/18/24; 12/02/24; 06/12/25<br>Annual Review Date: 06/11/25 |

**I. POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to perform medical procedures in a safe, standardized, and patient-centered manner consistent with approved clinical protocols, scope of practice, and evidence-based standards.

**II. PURPOSE:** To ensure all procedures are performed with appropriate consent, safety measures, and clinical oversight to minimize risk and promote positive patient outcomes.

**III. SCOPE:** Applies to all clinical staff performing or assisting with medical procedures at NACA.

**IV. SAFETY STANDARDS**

- All procedures must be performed using appropriate infection control practices consistent with CDC guidelines
- Equipment must be properly maintained and available
- Emergency response equipment must be accessible when indicated

**V. CONSENT REQUIREMENTS**

- Informed consent must be obtained prior to all procedures as appropriate
- The consent process must include:
    - Explanation of the procedure
    - Risks and benefits
    - Alternatives
- Consent must be documented in the Electronic Health Record (EHR)

**VI. SCOPE OF PRACTICE**

- Procedures must be performed only by staff who are:
    - Licensed (if required)
    - Credentialed and privileged (if applicable)
    - Competent and trained

**VII. GOVERNANCE:** All procedural standards, protocols, and standing orders are approved by the Medical Director in accordance with MS 200 Clinical Governance.

**VIII. DOCUMENTATION REQUIREMENTS**

- Procedure details must be documented in the EHR
- Consent must be recorded
- Any complications or adverse events must be documented

## IX. COMPLIANCE AND MONITORING

- Chart audits of procedural documentation
- Review of adverse events or complications

## X. REFERENCES

- MS 200 Clinical Governance Policy
- CDC Infection Control Guidelines
- AAAHC Standards

**MS340A Medical Procedures Procedure**

1. PURPOSE

To establish standardized procedures for the safe, consistent, and high-quality performance of medical procedures within the organization.

2. SCOPE

This procedure applies to all clinical staff involved in performing, assisting with, or supporting medical procedures at the Family Health Center.

3. RESPONSIBILITIES

- Medical Providers (MD, DO, NP, PA)
  - Perform procedures within scope of practice and privileging
  - Obtain informed consent
  - Conduct risk assessment and determine clinical appropriateness
  - Remain present for the duration of the procedure
  - Document all procedures in the EHR
- Nursing Staff (RN) and Medical Assistant
  - Assist with preparation, monitoring, and post-procedure care
  - Verify equipment readiness and safety compliance
  - Support patient education and follow-up

4. GENERAL PROCEDURAL REQUIREMENTS

- All procedures must be performed by qualified and credentialed staff.
- Procedures must be consistent with approved clinical guidelines and organizational protocols.
- Appropriate infection control practices shall be followed at all times.
- Required equipment, supplies, and emergency equipment must be available prior to initiating the procedure.

5. PRE-PROCEDURE PROCESS

- Clinical Assessment
  - Review medical history, allergies, and current medications
  - Evaluate comorbidities and procedural risk
  - Determine if procedure is appropriate for the clinical setting
- Patient Consent
  - Explain procedure, risks, benefits, and alternatives
  - Obtain and document informed consent prior to initiation
- Preparation
  - Verify required supplies and equipment
  - Ensure appropriate staffing and assistance
  - Prepare patient and procedural site using aseptic technique

6. TIME-OUT (REQUIRED)

- Requirement
    - A standardized Time-Out shall be performed immediately prior to all invasive or high-risk procedures.
- Process The procedural team must verbally confirm:
    - Correct patient (using two identifiers)
    - Correct procedure
    - Correct site and laterality (if applicable)
    - Availability of required equipment
- Participation
    - All team members involved in the procedure must actively participate
- Documentation
    - Completion of the Time-Out must be documented in the EHR

7. INTRA-PROCEDURE CARE

- Maintain aseptic technique and infection control practices
- Monitor patient condition throughout the procedure
- Use appropriate anesthesia and pain management as indicated
- Ensure provider presence for the duration of the procedure

8. POST-PROCEDURE CARE

- Immediate Care
    - Assess patient for complications
    - Provide wound care and stabilization as needed
- Patient Education Provide and document instructions regarding:
    - Pain management
    - Activity restrictions
    - Signs and symptoms of complications
    - Follow-up care and when to seek medical attention
- Follow-Up
        - Schedule follow-up appointments as appropriate
        - Ensure continuity of care and referral if needed

9. PEDIATRIC CONSIDERATIONS

- Use age-appropriate equipment and dosing
- Modify care plans based on developmental needs
- Ensure guardian involvement as appropriate
- Monitor for pediatric-specific risks and complications

10. MEDICATION AND ANESTHESIA MANAGEMENT

- Review current medications prior to procedure
- Assess for contraindications and drug interactions
- Use appropriate anesthetic agents within scope
- Educate patient on post-procedural medication use

DOCUMENTATION REQUIREMENTS

The following must be documented in the EHR:

- Pre-procedure assessment
- Informed consent
- Time-Out completion
- Procedure performed and technique used
- Medications/anesthesia administered
- Patient tolerance and outcomes
- Post-procedure instructions
- Follow-up plan

ESCALATION AND EMERGENCY RESPONSE

- Any complication or unexpected outcome shall be immediately addressed
- Activate emergency response protocols as needed
- Transfer to higher level of care if indicated (see MS 110)
- Document all events and actions taken

QUALITY AND COMPLIANCE MONITORING

- Procedures shall be subject to periodic review through Quality Improvement processes
- Compliance with documentation, safety protocols, and outcomes shall be monitored
- Identified issues shall be addressed through corrective action plans

A. Lesion excisions are medical procedures performed by NACA Doctor of Osteopathic (DO), Doctor of Medicine (MD), Nurse Practitioner (NP), and/or Physician Assistant. Lesion excisions are minor procedures to remove a piece of skin tissue. There are many medical techniques that can be utilized to perform a lesion excision. Lesion excisions are often done in conjunction with a local anesthetic. Lesion excisions are performed at NACA for the following purposes:
   - To make a diagnosis
   - To improve the cosmetic appearance (i.e., removal of skin tags or warts)
   - To relieve symptoms (i.e., pain)
   - To remove an inflamed or frequently infected cyst

B. NACA performs the following types of lesion excisions:
   - Cryotherapy technique requires application of extreme cold to freeze and remove lesions.
   - Electrocautery technique that uses an electrical current to apply heat to tissue using a handheld probe similar to a pen.
   - Hyfrecator technique that uses a low powered electrosurgical device that emits electrical pulses, via an electrode mounted on a handpiece, directly to the affected area of the body.
   - Punch biopsy technique that uses a hollow, circular scalpel, which is attached to a pencil-like handle to cut into and around a skin lesion.
   - Shave excision technique that uses a small blade to remove the outermost layers of skin.

C. Skin debridement is a medical procedure performed by NACA Doctor of Osteopathic (DO), Doctor of Medicine (MD), Nurse Practitioner (NP), and/or Physician Assistant. Skin debridement is a procedure to aid in managing chronic wounds to heal more quickly so it can be closed. This procedure is often performed with local anesthetic. The goal of debridement is to rid the wound of any foreign material and contaminated/damaged tissue, which in turn will help it heal more quickly. There are different types of skin debridement. NACA provides the following debridement type(s):

- Conservative sharp debridement. This involves the use of scalpels, curettes, or scissors.

D. Skin laceration repair is a medical procedure performed by NACA Doctor of Osteopathic (DO), Doctor of Medicine (MD), Nurse Practitioner (NP), and/or Physician Assistant. Skin laceration repair is used to close minor wounds that extend through the dermis and are likely to cause scarring. This procedure is performed with local anesthetic. There are various techniques physicians use to repair skin lacerations. NACA physicians use the following techniques:
   - Sutures
   - Staples
   - Skin-closure tape
   - Tissue adhesive

E. Abscess incision and drainage is a medical procedure performed by NACA Doctor of Osteopathic (DO), Doctor of Medicine (MD), Nurse Practitioner (NP), and/or Physician Assistant. A skin abscess is a pocket of pus just under an inflamed section of skin. Abscess incision and drainage procedures are typically used to clear a skin abscess of pus and start the healing process. It is administered with a needle in conjunction with a local anesthetic.

F. Ingrown toenail excision is a medical procedure performed by NACA Doctor of Osteopathic (DO), Doctor of Medicine (MD), Nurse Practitioner (NP), and/or Physician Assistant. An ingrown toenail excision involves removing the portion of nail or skin that is creating the problem. In some cases, this requires removal of the entire nail. The physician uses a variety of tools to perform the excision, including, but not limited to, nail scissors, forceps, and scalpels. The excision may also involve a local anesthetic.

G. Joint injection is a medical procedure performed by NACA Doctor of Osteopathic (DO), Doctor of Medicine (MD), Nurse Practitioner (NP), and/or Physician Assistant. A joint injection is a shot that contains Cortisone or Kenalog. The injection typically contains a local anesthetic. Joint injections are performed at NACA for the following purposes:
   - Pain relief
   - Bursitis
   - Osteoarthritis
   - General wear and tear

H. Joint aspiration is a medical procedure performed by NACA Doctor of Osteopathic (DO) and/or Doctor of Medicine to remove fluid from the space around a joint using a needle and syringe. Joint aspiration is most often done on the knee. However, fluid can also be removed from other joints, such as the hip, ankle, shoulder, elbow, or wrist. Joint aspirations are usually done under a local anesthetic. Joint aspirations are performed at NACA for the following purposes:
   - Pain relief
   - Decrease swelling

I. Trigger point injection is a medical procedure used to relieve pain in specific areas of muscle tightness, known as trigger points, performed by NACA Doctor of Osteopathic (DO), Doctor of

Medicine (MD), Nurse Practitioner (NP), and/or Physician Assistant. Injections generally consist of a local anesthetic, corticosteroid, and/or botulinum toxin and are injected into various locations

of the body such as the neck, shoulders, back, arms and legs. Trigger Point injections are performed at NACA for the following purposes:

- Pain relief
- Improved mobility
- Reduced muscle tension
- Non-surgical treatment option

J. IUD insertion and excision is a medical procedure performed by NACA Doctor of Osteopathic (DO), Doctor of Medicine (MD), Nurse Practitioner (NP), and/or Physician Assistant. IUDs are T-shaped devices placed inside the uterus. This procedure may be performed with topical anesthetic. IUD insertion and excisions are performed at NACA for the following purposes:

- Pregnancy contraception
- Hormonal regulation
- Heavy menstrual bleeding
- Painful menstrual bleeding

K. Nexplanon insertion and excision is a medical procedure performed by NACA Doctor of Osteopathic (DO), Doctor of Medicine (MD), Nurse Practitioner (NP), and/or Physician Assistant. NEXPLANON insertion and excision are performed with local anesthetic at NACA for the following purposes:

- Pregnancy contraception
- Menstrual irregularities

L. Endometrial biopsy is a medical procedure performed by NACA Doctor of Osteopathic (DO), Doctor of Medicine (MD), Nurse Practitioner (NP), and/or Physician Assistant. The endometrial biopsy involves taking a tissue sample of the lining of the uterus and can be performed under topical anesthetic. The sample is evaluated to aid the physician in forming a diagnosis. Endometrial biopsy is performed at NACA for the following purposes:

- Diagnosis abnormal pap smear
- Diagnosis abnormal vaginal bleeding

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| **POLICY: MS 350** | (X) Revision<br>( ) New | Original Issue Date: 03/04/24<br>Revised Date: 03/08/24; 07/12/24<br>Approved by: Board of Directors<br>Approval Date: 03/20/24; 07/17/24; 06/11/25<br>Effective Date: 03/21/24; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |
| **Geriatric Care** | Author: Medical Staff Committee | |

**I. POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to provide comprehensive, patient-centered care to geriatric patients that addresses medical, functional, cognitive, and social needs in accordance with evidence-based practices.

**II. PURPOSE:** To promote safe, effective, and coordinated care for older adults, with emphasis on early identification of risks, prevention of functional decline, and management of chronic conditions.

**III. SCOPE: Applies** to all clinical staff providing care to geriatric patients at NACA.

**IV. STANDARDS:**

- Care must address physical, cognitive, and functional health
- Preventive screenings and risk assessments must be incorporated into routine care
- Care must align with evidence-based geriatric clinical guidance
- Polypharmacy risks must be actively managed

**V. GOVERNANCE:** All geriatric care protocols and standing orders are approved by the Medical Director and reviewed annually in accordance with MS 200.

**VI. REFERENCES:**

- CDC Older Adult Health Guidance
- AAAHC Standards
- IHS Clinical Guidelines

## MS 350A – GERIATRIC CARE PROCEDURE

1. Patient Identification
   - Patients aged 65 and older are identified for geriatric-focused care considerations.

2. Comprehensive Assessment
   - At routine visits, staff evaluate:
     - Functional status (ADLs/IADLs)
     - Mobility and fall risk factors
     - Cognitive concerns
     - Medication use

3. Preventive and Chronic Care
   - Address:
     - Preventive screenings (per MS 300 / MS 331)
     - Chronic disease management (MS 310 / MS 320)
     - Immunizations

4. Medication Review
   - Providers must review all medications for:
     - Duplication
     - Drug interactions
     - High-risk medications for older adults
   - Adjustments are made as clinically indicated

5. Care Coordination
   - Coordinate with caregivers, specialists, and community services as needed

6. Patient and Caregiver Education
   - Provide education on:
     - Fall prevention
     - Medication safety
     - Disease management

DOCUMENTATION REQUIREMENTS:
- Functional, cognitive, and medication assessments must be documented in the EHR
- Identified risks and care plans must be recorded

COMPLIANCE AND MONITORING:
- Chart audits for geriatric assessment completion
- Monitoring of medication safety
- Tracking of fall risk and screening compliance

## MS350B GERIATRIC CLINICAL PROTOCOL

**I. PURPOSE:** To provide standardized clinical criteria for identifying and managing common geriatric risks including falls and cognitive impairment.

### II. FALL RISK ASSESSMENT

Screening Criteria: All patients aged 65 and older must be evaluated for fall risk annually or when clinically indicated.

Risk Indicators:

- History of falls in past 12 months
- Difficulty with balance or gait
- Use of assistive devices
- Polypharmacy or high-risk medications (e.g., sedatives)
- Visual impairment

Actions:

High-risk patients require:

- Provider review
- Fall prevention plan
- Consider PT or community referral

### III. COGNITIVE SCREENING

Screening is required when:

- Memory concerns are reported
- Functional decline is observed

At annual preventive visits (recommended)

Tools (examples):

- Mini-Cog
- MOCA (if applicable)

Actions:

Abnormal results require:

- Provider evaluation
- Further diagnostic workup
- Caregiver involvement as appropriate

### IV. POLYPHARMACY MANAGEMENT (REQUIRED ADDITION)

Polypharmacy is defined as the concurrent use of multiple medications (typically 5 or more).

Providers must:

- Review all medications at each visit
- Identify high-risk medications (e.g., Beers Criteria)
- Discontinue or adjust medications when clinically appropriate

Escalation required if:

- Adverse drug effects suspected
- Medication-related falls or confusion

## V. ESCALATION CRITERIA

Immediate provider involvement required for:

- Recurrent falls
- Acute confusion or delirium
- Significant functional decline
- Medication-related adverse events

## VI. AUTHORITY AND STANDING ORDERS

This protocol is approved by the Medical Director of NACA

Standing orders may allow staff to:

- Initiate fall risk screening
- Perform cognitive screening tools
- Document findings in the EHR
- All abnormal findings must be reviewed by a licensed provider

## VII. DOCUMENTATION REQUIREMENTS

The following must be documented:

- Fall risk status
- Cognitive screening results
- Medication review and changes
- Follow-up plan

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| **POLICY: MS 360** | (X) Revision<br>( ) New | Original Issue Date: 03/04/24<br>Revised Date: 03/08/24; 07/12/24; 11/11/24; 06/02/25 |
| **Pediatric Care (Birth – 17 years)** | Author: Medical Staff Committee | Approved by: Board of Directors<br>Approval Date: 03/20/24; 07/17/24; 11/20/24; 06/11/25<br>Effective Date: 03/21/24; 07/18/24; 12/02/24; 06/12/25<br>Annual Review Date: 06/11/25 |

**I. POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to ensure the well-being, safety, and development of children and address their unique healthcare needs between birth and age 17 years.

**II. PURPOSE:** The purpose of this pediatric care policy for primary care is to outline the standards and guidelines for delivering comprehensive, high-quality healthcare services to children and adolescents in a primary care setting.

**III. SCOPE:** Applies to all clinical staff providing care to pediatric patients (birth through adolescence) at NACA.

**IV. STANDARDS**

- Care follows established pediatric preventive care and screening guidelines
- Immunizations align with CDC recommendations
- Growth, development, and behavioral health are routinely assessed
- Patient safety and mandated reporting requirements are enforced

**V. GOVERNANCE:** All pediatric protocols and standing orders are approved by the Medical Director and reviewed annually in accordance with MS 200.

**VI. REFERENCES**

- CDC Immunization Schedule
- Bright Futures / AAP Guidelines
- AAAHC Standards

## MS 360A – PEDIATRIC CARE PROCEDURE

I. Patient Identification
- Pediatric patients are defined as individuals from birth through adolescence.

II. Preventive and Routine Care
- Provide routine well-child visits per established schedules
- Assess growth, development, and behavioral health

III. Immunization Assessment
- Review immunization status at each visit
- Administer vaccines per protocol and standing orders

IV. Developmental and Behavioral Screening
- Perform age-appropriate screenings
- Identify delays and refer as needed

V. Care Coordination
- Coordinate care with:
- Specialists
- Schools
- Community services

VI. Mandatory Reporting
- Staff must report suspected abuse or neglect in accordance with state law
- Reports must be made immediately upon suspicion
- Documentation must reflect:
    - Observations
    - Actions taken
    - Reporting details

VII. Documentation Requirements:
- Growth and developmental assessments must be recorded in the HER
- Immunizations and screenings must be documented
- Mandatory reporting actions must be documented

VIII. Compliance and Monitoring:
- Chart audits for pediatric preventive care compliance
- Immunization rate monitoring
- Review of mandatory reporting adherence

## MS360B PEDIATRIC CLINICAL PROTOCOL

**I. PURPOSE:** To standardize pediatric preventive care, including well-child visits and immunization practices, in accordance with national guidelines.

### II. WELL-CHILD VISIT SCHEDULE

Well-child visits shall follow evidence-based schedules, including:

- Newborn and infancy:
  - 3–5 days after birth
  - 1 month
  - 2, 4, 6, 9, and 12 months
- Early childhood:
  - 15, 18, and 24 months
  - 30 months
- Annual visits
  - Ages 3 through adolescence (yearly)
- Each visit must include:
  - Growth measurements (height, weight, BMI)
  - Developmental screening
  - Behavioral and mental health assessment
  - Preventive counseling

### III. IMMUNIZATION PROTOCOL (CDC-ALIGNED)

- Immunizations must follow the current CDC-recommended schedule
- Vaccines are administered according to age and risk factors
- Contraindications must be reviewed prior to administration
- Missed vaccines must be addressed through catch-up schedules

### IV. DEVELOPMENTAL AND BEHAVIORAL SCREENING

- Screening must include:
  - Developmental milestones at designated ages
  - Autism screening at appropriate intervals
  - Behavioral and mental health screening as indicated
- Abnormal findings require:
  - Provider review
  - Referral to appropriate services

### V. ESCALATION CRITERIA

- Provider evaluation is required for:
  - Developmental delays
  - Behavioral or mental health concerns
  - Abnormal growth patterns
  - Missed or delayed immunizations requiring catch-up planning

## VI. MANDATORY REPORTING (CRITICAL ADDITION)

- All staff at NACA are mandated reporters.
- Reporting is required for:
    - Suspected child abuse or neglect
    - Physical, emotional, or sexual abuse
    - Unsafe living conditions
- Requirements:
    - Reports must be made immediately upon suspicion
    - Staff must follow state-specific reporting procedures
    - Documentation is required but does not replace reporting
- Failure to report may result in legal consequences.

## VII. AUTHORITY AND STANDING ORDERS

- This protocol is approved by the Medical Director of NACA.
- Standing orders may authorize:
    - Administration of routine immunizations
    - Performance of developmental screening tools
    - Identification of care gaps
- All abnormal results or concerns must be reviewed by a licensed provider.

## VIII. DOCUMENTATION REQUIREMENTS

- The following must be documented:
    - Well-child visit completion
    - Immunization status and administration
    - Screening results
    - Any mandatory reporting actions taken

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| **POLICY: MS 400** | (X) Revision<br>( ) New | Original Issue Date: 12/01/18<br>Revised Date: 09/03/20; 07/12/24<br>Approved by: Board of Directors<br>Approval Date: 09/16/20; 07/17/24; 06/11/25<br>Effective Date: 09/17/20; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |
| **Chronic Non-Cancer Pain Management** | Author: Medical Staff Committee | |

**I. POLICY:** It is the policy of Native Americans for Community Action, Inc (NACA) to provide evidence-based, patient-centered, and culturally responsive care for patients with chronic non-cancer pain. All prescribing follows CDC guidelines, Arizona regulations, and AAAHC standards.

**II. PURPOSE:** To ensure appropriate, safe, and consistent management of chronic pain while minimizing risk associated with opioid and other therapies.

**III. SCOPE:** Applies to all providers involved in the evaluation and management of patients with chronic pain at NACA.

**IV. GOVERNANCE:** All chronic pain management protocols and prescribing practices are approved by the Medical Director and reviewed annually in accordance with MS 200 Clinical Governance.

**V. DEFINITIONS**

- Chronic Pain: Pain lasting ≥3 months
- MME: Morphine Milligram Equivalent
- Aberrant behavior: Concerning medication-related behavior (e.g., misuse, diversion)
- Pharmacy Drug Monitoring Program (PMDP): State level electronic database that tracks the prescribing and dispensing of controlled substances.

**VI. STANDARDS OF CARE**

- Care must follow current CDC opioid prescribing guidance and evidence-based practices
- Non-pharmacologic and non-opioid therapies are prioritized when appropriate
- Risk assessment and monitoring are required for all patients receiving controlled substances
- Opioid prescribing decisions must be individualized based on patient-specific clinical factors
- Dosage thresholds, including morphine milligram equivalents (MME), are not to be used as rigid limits but as clinical reference points
- Providers must avoid rigid application of dosage thresholds and instead apply clinical judgment
- Clinical decisions for chronic pain management at NACA are individualized and not based on fixed thresholds.
- Treatment plans must reflect patient-specific risks, benefits, and goals of care.

## VII. RISK MANAGEMENT

- Patients receiving opioid therapy must undergo:
  - Risk assessment (e.g., substance use risk)
  - Periodic review of treatment effectiveness
  - Monitoring for adverse effects and misuse

## VIII. CARE APPROACH

- Emphasis on:
  - Functional improvement
  - Patient engagement
  - Multimodal care strategies

## IX. DOCUMENTATION REQUIREMENTS

- Pain assessment, treatment plan, and risk evaluation must be documented in the EHR
- Clinical decision-making, including deviations from typical dosing ranges, must be justified

## X. COMPLIANCE AND MONITORING

- Chart audits for opioid prescribing practices
- Monitoring of controlled substance use
- Quality review aligned with safety standards

## XI. REFERENCES


- CDC Clinical Practice Guideline for Prescribing Opioids (2022 update)
- AAAHC Standards
- MS 200 Clinical Governance Policy

**MS400A CHRONIC PAIN CLINICAL PROTOCOL**

**I. PURPOSE:** To establish standardized, evidence-based clinical guidance for the evaluation and management of chronic pain, ensuring safe, individualized, and effective treatment.

**II. DEFINITION OF CHRONIC PAIN:** Chronic pain is defined as pain lasting longer than 3 months or beyond expected tissue healing time.

**III. INITIAL ASSESSMENT**

- Required for all patients:
  - Pain history
  - Location, duration, intensity, character
  - Impact on function and quality of life

- Functional assessment:
  - Activities of daily living (ADLs)
  - Work and social function

- Medical history:
  - Comorbid conditions
  - Behavioral health conditions

- Medication history:
  - Current and prior therapies
  - Response and side effects

- Risk assessment:
  - Substance use history
  - Behavioral health risk factors

**IV. TREATMENT APPROACH**

- Management must prioritize:
  - Functional improvement over pain elimination
  - Patient-centered and culturally responsive care
  - Multimodal treatment strategies

- All treatment decisions must be individualized and not based on fixed thresholds.
- Clinical judgment must guide therapy selection, dosing, and adjustments**.**

**V. NON-OPIOID AND NON-PHARMACOLOGIC THERAPIES (FIRST LINE)**

- Providers should prioritize:
  - Physical therapy
  - Exercise programs
  - Behavioral therapies

    - Lifestyle modifications
    - Non-opioid medications (NSAIDs, acetaminophen, etc.)
- These therapies should be optimized before initiating opioid treatment when appropriate.

**VI. OPIOID THERAPY (IF INDICATED)**

- Opioids may be considered when:
    - Benefits outweigh risks
    - Other therapies are insufficient or contraindicated
    - Functional goals are clearly defined

- Dosing Principles:
    - Use the lowest effective dose
    - Avoid rigid MME thresholds
    - MME values serve as clinical reference points only
    - Dose escalation must be clinically justified and documented

- **Patients must be informed about:**
    - Risks and benefits of opioid therapy
    - Expected outcomes (function vs pain reduction)
    - Safe use and storage

**VII. RISK MITIGATION REQUIREMENTS**

- Required for opioid therapy:
    - Prescription Drug Monitoring Program (PDMP) review:
    - At initiation and periodically

- Urine Drug Screening (UDS):
    - At baseline and periodically based on risk

- Risk assessment tools:
    - As clinically appropriate

- Pain management agreement:
    - For ongoing opioid therapy

**VIII. MONITORING AND FOLLOW-UP**

- Patients receiving chronic pain treatment must be reassessed regularly for:
    - Pain control
    - Functional improvement
    - Side effects
    - Signs of misuse or diversion

- Follow-up frequency based on:
    - Risk level
    - Stability of condition

- Medication regimen

## IX. TAPERING AND DISCONTINUATION

- Tapering should be considered when:
  - Risks outweigh benefits
  - No functional improvement is observed
  - Misuse or safety concerns arise
- Tapering must:
  - Be individualized
  - Occur gradually when possible
  - Include patient engagement and support

## X. ESCALATION CRITERIA

- Provider review and/or modification required for:
  - Lack of improvement in function
  - Adverse medication effects
  - Evidence of misuse or diversion
  - Complex pain syndromes
  - Behavioral health concerns

## XI. REFERRALS

- Referral to specialty care (e.g., pain management, behavioral health) is indicated when:
  - Pain is refractory to treatment
  - Complex medication management required
  - Behavioral health factors impact care

## XII. AUTHORITY AND SCOPE

- This protocol is approved by the Medical Director of Native Americans for Community Action, Inc. (NACA)
- Providers are responsible for all prescribing decisions
- Nursing staff may support monitoring and education within scope
- Medical Assistants may support documentation and screening

## XIII. DOCUMENTATION REQUIREMENTS

- The following must be documented in the EHR:
  - Pain assessment
  - Functional status
  - Treatment plan
  - Risk assessment
  - Monitoring activities (PDMP, UDS)
  - Clinical justification for therapy decisions
  - Patient education and consent

**OPIOID AGREEMENT and CONSENT- Chronic Pain Care**

**Our Shared Goal**

We will work together to:

- Improve your function, not just reduce pain
- Use the safest and most effective treatments

**What You Can Expect From Us**

- Care based on current medical guidelines
- Safe prescribing and monitoring
- Respect for your culture, values, and preferences
- Access to other treatments (therapy, PT, etc.)

**Your Responsibilities**

**1. Safe Medication Use**

- Take medications exactly as prescribed
- Do not share, sell, or misuse medications
- Store medications securely

**2. One Provider / One Pharmacy**

- Get controlled medications only from this clinic
- Use one pharmacy unless approved

**3. Monitoring**

You agree to:

- Periodic urine drug testing
- PDMP review
- Regular follow-up visits

**4. Appointments**

- Keep scheduled visits
- No early refills without approval
- Refills require a visit monthly

**5. Safety Rules**

- Do not mix opioids with alcohol or unauthorized drugs
- Avoid driving or dangerous activities if impaired
- Keep medications out of reach of others

**Reasons Therapy May Change or Stop**

- No improvement in function
- Side effects or safety concerns
- Missed appointments

- Evidence of misuse/diversion

**Important Risks**

- Drowsiness, constipation, slowed breathing
- Dependence and withdrawal
- Overdose (can be fatal)

**Naloxone**

You may receive a prescription for naloxone, a medication that reverses overdose.

**Acknowledgment**

By signing, you confirm:

- You understand the risks and expectations
- You agree to follow this care plan

Patient Print Name: _____ Date: _____

Patient Sign Name: _____

Provider Print Name: _____ Date: _____

Provider Sign Name: _____

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| **POLICY: MS 410** | (X) Revision<br>( ) New | Original Issue Date: 03/04/24<br>Revised Date: 03/08/24; 07/12/24<br>Approved by: Board of Directors<br>Approval Date: 03/20/24; 07/17/24; 06/11/25<br>Effective Date: 03/21/24; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |
| **Assessment and Management of Acute Pain** | Author: Medical Staff Committee | |

**I.** **POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to provide safe, effective, and patient-centered management of acute pain using evidence-based practices and individualized clinical decision-making.

**II.** **PURPOSE:** To establish standardized expectations for the evaluation and management of acute pain, ensuring consistent, safe, and evidence-based care while reducing risk associated with inappropriate opioid use.

**III.** **SCOPE:** This policy applies to all licensed providers and clinical staff involved in the assessment and management of acute pain at Native Americans for Community Action, Inc. (NACA).

**IV.** **GOVERNANCE:** All acute pain management practices, including prescribing protocols and procedures, are approved by the Medical Director in accordance with MS 200 Clinical Governance. Clinical protocols (MS 410B) and procedures (MS 410A) supporting this policy are reviewed annually and updated based on current evidence, including CDC guidance. Only licensed providers are authorized to prescribe controlled substances.

**V.** **DEFINITION:** Acute pain is defined as pain of recent onset, typically associated with injury, illness, or medical procedures, and expected to resolve within a limited period.

**VI.** **STANDARDS OF CARE:**

- Acute pain management at NACA shall adhere to the following standards:
  - Evidence-Based Practice: Care must align with current clinical guidelines, including CDC opioid prescribing guidance and applicable specialty recommendations.
  - Individualized Care: All clinical decisions regarding pain management must be individualized and not based on fixed thresholds.
  - Treatment plans must consider:
    - Patient condition
    - Severity of pain
    - Functional impact
    - Risk factors
  - Multimodal Therapy
    - Non-pharmacologic and non-opioid therapies shall be prioritized when appropriate.

- Safe Opioid Use
    - They must be used at the lowest effective dose
    - For the shortest duration necessary
    - With clear clinical justification
- Functional Improvement
    - Treatment goals must emphasize restoration of function and recovery rather than complete elimination of pain.
- Risk Management
    - Providers must assess risk factors for adverse outcomes, including:
        - Substance use risk
        - Medication interactions
        - Comorbid conditions
        - Opioid prescribing decisions must be guided by clinical judgment and patient-specific factors
        - Duration and dosage recommendations are intended as guidelines, not rigid limits
        - Providers must avoid strict adherence to fixed thresholds and instead apply individualized decision-making
        - Short-term opioid therapy for acute pain typically should not exceed the expected duration of severe pain; however, all prescribing decisions must be based on clinical assessment.

## VII. PATIENT EDUCATION REQUIREMENTS

- Patients receiving treatment for acute pain must be provided education regarding:
    - Expected course of pain
    - Proper medication use
    - Risks and side effects
    - Safe storage and disposal of medications

## VIII. DOCUMENTATION REQUIREMENTS

- The following must be documented in the Electronic Health Record (EHR):
    - Pain assessment and clinical findings
    - Treatment plan and rationale
    - Medications prescribed, including duration
    - Patient education provided
    - Follow-up instructions
    - Any deviation from typical treatment patterns must be justified and documented.

## IX. COMPLIANCE AND MONITORING

- Compliance with this policy is monitored through:
    - Chart audits of acute pain management practices

- Review of prescribing patterns
- Quality improvement activities
- Monitoring for repeat or prolonged acute pain presentations

## X. REFERENCES

- CDC Clinical Practice Guideline for Prescribing Opioids
- AAAHC Standards
- MS 200 Clinical Governance Policy

**MS410A ACUTE PAIN MANAGEMENT PROCEDURE**

1. Patient Presentation
    - Patient presents with complaint of acute pain
    - Patient Services Coordinator (PSC) or clinical staff initiates intake

2. Initial Assessment

Clinical staff (MA/RN) collect and document:

- Chief complaint
- Pain location, duration, and severity
- Relevant history (injury, illness, recent procedures)
- Vital signs

Abnormal findings must be escalated to RN or Provider immediately

3. Provider Evaluation

Provider performs:

- Focused clinical evaluation
- Determination of underlying cause of pain
- Assessment of severity and functional impact
- Review of medical, medication, and risk history

4. Treatment Planning

Provider develops individualized treatment plan prioritizing:

- Non-pharmacologic therapies (rest, ice, etc.)
- Non-opioid medications (NSAIDs, acetaminophen)

Short-term opioid therapy may be considered if:

- Pain is moderate to severe
- Other therapies are insufficient
- Benefits outweigh risks

5. Patient Education

Patient must receive education regarding:

- Expected duration of pain
- Proper medication use
- Risks and side effects
- Safe storage and disposal (if opioids prescribed)

6. Follow-Up Planning

Follow-up is arranged based on:

- Severity of condition
- Type of treatment
- Risk factors

Patients must be advised to return for:

- Worsening pain

- Lack of improvement
- New or concerning symptoms

7. Documentation

All care must be documented in the EHR, including:

- Pain assessment findings
- Clinical diagnosis (if known)
- Treatment plan and rationale
- Medications prescribed (dose and duration)
- Patient education provided
- Follow-up instructions

DOCUMENTATION REQUIREMENTS

- Complete and accurate documentation is required for all acute pain encounters
- Any deviation from standard treatment patterns must be justified

COMPLIANCE AND MONITORING

- Chart audits of acute pain management practices
- Monitoring of prescribing patterns
- Review of repeat visits and escalation trends

**MS410B ACUTE PAIN CLINICAL PROTOCOL**

## I. PURPOSE

To provide standardized clinical guidance for safe, effective, and individualized management of acute pain, including appropriate use of opioid therapy.

## II. GENERAL PRINCIPLES

- Acute pain is expected to be self-limited
- Management must focus on short-term relief and functional recovery
- Clinical decisions must be individualized and not based on fixed thresholds

## III. FIRST-LINE MANAGEMENT

Providers should prioritize:

- Non-pharmacologic therapies:
  - Rest
  - Ice or heat
  - Immobilization (if indicated)
- Non-opioid medications:
  - NSAIDs
  - Acetaminophen

## IV. OPIOID PRESCRIBING GUIDELINES

- Opioids may be considered when:
  - Pain is severe
  - Non-opioid therapies are insufficient
  - Benefits outweigh risks

## V. DURATION AND DOSING

- Prescribe the lowest effective dose
- Prescriptions should be limited to the expected duration of severe pain
- Typical duration:
  - 3–7 days or less for most acute conditions
- IMPORTANT:
  - Duration limits are guidelines, not rigid rules
  - Clinical judgment must guide all prescribing decisions

## VI. ADDITIONAL SAFETY CONSIDERATIONS

- Evaluate patient risk factors (substance use, comorbidities)
- Avoid concurrent sedating medications when possible
- Consider PDMP review when clinically appropriate

## VII. ESCALATION CRITERIA

- Provider reassessment is required when:
  - Pain persists beyond expected duration

- Additional opioid prescriptions are requested
- Functional status does not improve
- Symptoms worsen or new findings emerge

**VIII. FOLLOW-UP AND TRANSITION OF CARE**

- Patients requiring prolonged pain management must be reassessed
- Consider transition to chronic pain management protocol (MS 400A) when appropriate

**IX. AUTHORITY AND SCOPE**

- This protocol is approved by the Medical Director of Native Americans for Community Action, Inc. (NACA)
- Only licensed providers may prescribe controlled substances
- RNs and MAs may support:
  - Assessment
  - Education
  - Monitoring (within scope)

**X. DOCUMENTATION REQUIREMENTS**

- The following must be documented:
  - Pain severity and cause
  - Treatment decision rationale
  - Medication details (dose, duration)
  - Patient education provided
  - Follow-up plan

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| **POLICY: MS 500** | (X) Revision<br>( ) New | Original Issue Date: 02/15/05<br>Revised Date: 09/03/20; 07/12/24<br>Approved by: Board of Directors<br>Approval Date: 09/16/20; 07/17/24; 06/11/25<br>Effective Date: 09/17/20; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |
| **HIV Testing and Counseling** | Author: Medical Staff Committee | |

**I. POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to provide routine, opt-out HIV screening and timely linkage to care in accordance with CDC recommendations.
HIV testing services must be delivered in a patient-centered, confidential, and culturally responsive manner, ensuring early diagnosis and prompt access to treatment.

**II. PURPOSE:** To standardize HIV screening practices and ensure timely identification, diagnosis, and linkage to care for patients.

**III. SCOPE:** Applies to all clinical staff involved in patient care, screening, testing, and follow-up at NACA.

**IV. GOVERNANCE:** All HIV testing protocols, procedures, and standing orders are approved by the Medical Director and reviewed annually in accordance with MS 200 Clinical Governance.

**V. STANDARDS OF CARE**

- HIV screening must follow CDC recommendations for routine, opt-out testing
- Patients must receive timely notification of results
- Positive results require prompt linkage to care
- Care must be culturally respectful and confidential

**VI. DOCUMENTATION REQUIREMENTS**

- HIV testing offers, acceptance/declination, and results must be documented in the HER
- Follow-up actions and referrals must be recorded

**VII. COMPLIANCE AND MONITORING**

- Monitoring of HIV screening rates
- Tracking linkage-to-care timelines
- Chart audits for documentation completeness

**VIII. REFERENCES**

- CDC HIV Screening Recommendations
- AAAHC Standards
- MS 200 Clinical Governance Policy

NATIVE AMERICANS FOR COMMUNITY ACTION

**MS500A HIV TESTING PROCEDURE**

1. Patient Identification
    - Patients eligible for screening are identified at routine visits

2. Offer of Testing
    - HIV screening is offered as routine opt-out testing
    - Patients are informed they may decline

3. Test Administration
    - Test is performed per approved methods (e.g., rapid or lab-based)
    - Staff follow infection control standards

4. Result Management
    - Negative results are communicated to the patient
    - Positive or reactive results trigger confirmatory testing and immediate notification of provider

5. Linkage to Care (CRITICAL STEP)
    - Patients with confirmed HIV diagnosis must be referred for care (Coconino County Health Department)
    - Follow-up coordination initiated immediately

6. DOCUMENTATION REQUIREMENTS
    - Offer, acceptance/declination, and results documented in EHR
    - All follow-up actions recorded

7. COMPLIANCE AND MONITORING
    - HIV testing rates reviewed
    - Timeliness of follow-up tracked

## MS500B HIV TESTING CLINICAL PROTOCOL

**I. PURPOSE:** To define standardized clinical criteria for HIV screening and ensure timely linkage to care.

### II. UNIVERSAL SCREENING CRITERIA

- All patients aged 13–64 should be screened for HIV at least once
- Screening is routine and opt-out (patients informed but not required to actively request)
- Repeat screening is recommended for patients with ongoing risk factors

### III. RISK-BASED SCREENING (ONGOING TESTING)

Patients with increased risk should be screened more frequently, including:

- Injection drug use
- Multiple sexual partners
- History of sexually transmitted infections
- Partner with known HIV infection

### IV. RESULT MANAGEMENT

- Reactive screening tests must be followed by confirmatory testing
- Providers must review all positive results

### V. LINKAGE TO CARE (CRITICAL REQUIREMENT)

Patients with confirmed HIV diagnosis must be linked to appropriate HIV medical care within 30 days of diagnosis.

Best practice goal:

- Initial linkage within 7–14 days when possible

Actions required:

- Referral to HIV specialty care
- Coordination with case management or support services
- Documentation of linkage completion

### VI. ESCALATION CRITERIA

Immediate provider involvement required for:

- Positive or reactive HIV test results
- High-risk patients requiring urgent follow-up

### VII. AUTHORITY AND STANDING ORDERS

This protocol is approved by the Medical Director of Native Americans for Community Action, Inc. (NACA).

Standing orders may authorize:

- Routine HIV screening for eligible patients
- Ordering of screening tests by nursing staff or other qualified personnel

- All positive results must be reviewed and managed by a licensed provider.

**VIII. DOCUMENTATION REQUIREMENTS**

The following must be documented:

- Screening eligibility and offer
- Patient acceptance or declination
- Test results
- Follow-up actions
- Linkage to care timeline (must meet ≤30-day requirement)

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| **POLICY: MS 600** | (X) Revision<br>( ) New | Original Issue Date: 02/15/05<br>Revised Date: 09/03/20; 07/12/24<br>Approved by: Board of Directors<br>Approval Date: 09/16/20; 07/17/24; 06/11/25<br>Effective Date: 09/17/20; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |
| **Additional Attendants During Examination** | Author: Medical Staff Committee | |

**I. POLICY:** The policy of NACA is to provide an additional attendant during examinations provided by a medical provider under certain circumstances and/or at the request of a patient.

**II. PURPOSE:** To ensure the comfort of all patients when being examined by a medical provider and to avoid legal complications due to misunderstanding of appropriate contact.

**III. PROCEDURE:**

- Female patients undergoing breast, pelvic, or rectal examinations, or any procedure where the removal of clothing is necessary, shall have an attendant present in addition to the examining medical provider upon request by the patient or medical provider.

- Male patients undergoing rectal or genitalia examinations, or any procedure requiring removal of clothing below the waist, shall have an attendant present in addition to the medical provider upon request by the patient or medical provider.

- For Well Child examinations, the parent/guardian and/or family member may act as the attendant at the discretion of the medical provider.

- An attendant shall be present during all examinations of sexual abuse or alleged rape. The attendant shall be the same sex as the patient and may be a nurse, medical assistant, or patient advocate, social worker.

- An attendant shall be provided for examinations whenever requested by the patient or the medical provider.

- The presence of an attendant during a patient encounter must be clearly documented in the Electronic Health Record (EHR). Documentation must include:

    - Confirmation or declination that an attendant was present ("Attendant present")
    - Role of the attendant, if applicable (e.g., chaperone, caregiver, support person)
    - Any relevant observations or actions related to the attendant's presence

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| **POLICY: MS 610** | (X) Revision<br>( ) New | Original Issue Date: 02/15/05<br>Revised Date: 09/03/20; 07/12/24<br>Approved by: Board of Directors<br>Approval Date: 09/16/20; 07/17/24; 06/11/25<br>Effective Date: 09/17/20; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |
| **Disclosure of Diagnosis and Prognosis** | Author: Medical Staff Committee | |

**I. POLICY:** It is the policy of NACA is to provide patients with accurate and timely information regarding their diagnosis, interventions, and prognosis.

**II. PURPOSE:** To ensure patients are provided information regarding their diagnosis, the reasons for tests and interventions, and their prognosis.

**III. PROCEDURE:**

- Patients shall be informed of any diagnostic conclusions reached by the medical provider following the medical provider's examination of the patient and review of information including, but not limited to, history, laboratory studies, radiological evaluations, and consultations with other medical providers and/or allied health professionals. Medical Provider may delegate communication of results to patient to Nursing Staff after their review; however the provider retains ultimate accountability.

- Patients shall be provided a reasonable prognostic outcome from any given diagnosis with an explanation regarding the unpredictability of the course of any given disease.

- Patients shall be informed of their diagnosis, prognosis, and/or test results at either their medical appointment, whenever possible, via a telephone call, or by certified letter marked confidential. Reasonable attempts to contact the patient shall be made.

- Diagnosis, prognosis, and/or test results, risks, benefits, and options of treatment. A translator shall be provided when necessary.

- All patient communication must be delivered in a manner that supports health literacy and patient understanding. Information must be:
    - Clear and understandable
    - Free of unnecessary medical jargon
    - Appropriate to the patient's literacy level

- Staff must use techniques such as:
    - Teach-back method
    - Plain language explanations
    - Visual aids when appropriate

- If a patient disagrees with the medical provider's diagnosis and/or prognosis, the patient has the right to obtain a second opinion.

- All information relayed to the patient shall be documented in the electronic health record (EHR) including:
    - Disclosure of relevant clinical information to the patient
    - Confirmation that information was provided

- If interpreter services are used, documentation must include:
    - Interpreter presence
    - Type of interpreter (in-person, telephonic, video)
    - Confirmation that interpretation was provided
    - Language Access: If a patient declines interpreter services, this must be documented
    - Use of interpreter services is required for patients with limited English proficiency when clinically necessary to ensure safe and effective communication.

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| **POLICY: MS 620** | (X) Revision<br>( ) New | Original Issue Date: 07/09/14<br>Revised Date: 09/03/20; 07/12/24; 06/02/25 |
| **Hospitalization and Transition of Care** | Author: Medical Staff<br><br>Committee | Approved by: Board of Directors<br><br>Approval Date: 09/16/20; 07/17/24; 06/11/25<br>Effective Date: 09/17/20; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |

**I.** **POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to ensure safe, timely, and coordinated transitions of care for patients discharged from hospitals or emergency departments. NACA will provide structured follow-up and care coordination to reduce risk of complications, improve outcomes, and support continuity of care.

**II.** **PURPOSE:** To establish standardized expectations for post-hospitalization follow-up, care coordination, and transitional care management to maintain patient safety and continuity of care.

**III.** **SCOPE:** Applies to all clinical staff involved in patient care, care coordination, and follow-up services at NACA.

**IV.** **GOVERNANCE:** All hospitalization follow-up processes and transitional care practices are approved by the Medical Director and reviewed annually in accordance with MS 200 Clinical Governance.

**V.** **STANDARDS OF CARE**

- All patients discharged from a hospital or emergency department must receive timely follow-up care.
- FOLLOW-UP TIMEFRAME (REQUIRED):
  - Patients must be scheduled for follow-up within 7–14 days of discharge.
  - Earlier follow-up must be arranged when clinically indicated.
  - Reviewing the received hospital discharge notifications in the EHR within 24–48 hours.
- CARE REQUIREMENTS:
  - Review of hospitalization or ED records when available
  - Medication reconciliation
  - Assessment of patient stability and care needs
  - Coordination with specialists and community resources as appropriate
- PATIENT SAFETY:
  - Emphasis on reducing readmissions and complications
  - Identification of high-risk patients for enhanced monitoring

## VI. DOCUMENTATION REQUIREMENTS

The following must be documented in the Electronic Health Record (EHR):

- Date and source of hospitalization or ED visit
- Follow-up contact attempts and completion
- Scheduled and completed follow-up visits
- Medication reconciliation
- Care coordination activities

## VII. COMPLIANCE AND MONITORING

Compliance is monitored through:

- Tracking follow-up within 7–14 days
- Review of care transition documentation
- Monitoring of TCM service utilization and billing compliance
- Evaluation of readmissions and care coordination effectiveness

## VIII. REFERENCES

- AAAHC Standards for Continuity of Care
- MS 200 Clinical Governance Policy

## MS620A HOSPTIALIZATION AND TRANSITION OF CARE PROCEDURE

1. Identification of Hospitalization or ED Visit
    - Patient hospitalization or ED visit is identified through:
        - Patient or caregiver report
        - Hospital notification
        - EHR alerts or tracking systems

2. Initial Patient Contact
    - Staff initiate contact as soon as possible after discharge (goal: within 2 business days when feasible)
    - Confirm:
        - Discharge status
        - Immediate needs
        - Understanding of discharge instructions

3. Scheduling Follow-Up
    - Schedule follow-up appointment:
        - Within 7–14 days of discharge
        - Earlier for high-risk or clinically complex patients

4. Medication Reconciliation
    - Review discharge medications against existing medication list
    - Identify discrepancies or safety concerns
    - Document reconciliation in the EHR

5. Clinical Follow-Up Visit
    - Provider evaluates:
        - Patient's current condition
        - Discharge instructions and adherence
        - Need for additional services or changes in care

6. Care Coordination
    - Coordinate care with:
        - Specialists
        - Behavioral health providers
        - Community resources
    - Ensure referrals are initiated and tracked

7. Escalation Criteria
    - Immediate provider review required for:
        - Worsening symptoms

- Medication-related concerns
- High-risk or unstable patients

Documentation Requirements

- All patient contact attempts and outcomes
- Follow-up scheduling and completion
- Medication reconciliation
- Care coordination actions and referrals

Compliance and Monitoring

- Audit of follow-up timing (7–14 days)
- Monitoring of documentation completeness

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| **POLICY: MS 630** | (X) Revision<br>( ) New | Original Issue Date: 04/14/22<br>Revised Date: 07/11/22; 07/12/24; 06/02/25 |
| **Point of Care Testing in Symptomatic Patients** | Author: Medical Staff Committee | Approved by: Board of Directors<br>Approval Date: 07/20/22; 07/17/24; 06/11/25<br><br>Effective Date: 07/21/22; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |

**I. POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to utilize point-of-care testing (POCT) to support timely clinical decision-making while ensuring accuracy, safety, and compliance with regulatory requirements. All POCT must be performed in accordance with approved procedures, clinical protocols, and CLIA-waived testing requirements.

**II. PURPOSE:** To establish standardized expectations for the safe, appropriate, and effective use of POCT in patient care.

**III. SCOPE:** Applies to all clinical staff performing or supporting point-of-care testing at NACA.

**IV. GOVERNANCE**: All POCT procedures and clinical protocols are approved by the Medical Director and reviewed annually in accordance with MS 200 Clinical Governance. Testing practices must comply with CLIA-waived testing regulations and applicable safety standards.

**V. STANDARDS OF CARE**

- POCT must only be performed when clinically appropriate
- Testing must follow standardized procedures to ensure accuracy
- Results must be reviewed and incorporated into patient care
- Staff performing testing must be trained and competency-validated

**VI. DOCUMENTATION REQUIREMENTS**

- Test performed
- Indication for testing
- Results
- Staff performing test
- Provider review (as appropriate)

**VII. COMPLIANCE AND MONITORING**

- Quality assurance review of testing accuracy
- CLIA compliance monitoring

- Competency validation for staff
- Chart audits for appropriate test use

## VIII. REFERENCES

- CLIA Waived Testing Regulations
- CDC Laboratory Testing Guidance
- AAAHC Standards
- MS 200 Clinical Governance Policy

## MS630A POINT-OF-CARE TESTING PROCEDURE

1. Patient Identification
   - Confirm patient identity using two identifiers
   - Verify clinical indication for testing

2. Test Selection
   - Select appropriate POCT based on presenting symptoms and clinical protocol (MS 630B)

3. Staff Authorization
   - Ensure staff performing test:
     - Are trained and competency-validated
     - Are authorized under CLIA-waived testing requirements

4. Test Performance
   - Perform test according to manufacturer instructions and NACA standards
   - Follow infection control procedures (hand hygiene, PPE as appropriate)

5. Result Recording
   - Record results immediately in the Electronic Health Record (EHR)
   - Ensure accuracy and completeness of data entry

6. Provider Notification
   - Notify provider of:
     - Positive or abnormal results
     - Critical values
     - Any unexpected findings

7. Follow-Up Actions
   - Provider reviews and determines:
     - Diagnosis
     - Treatment plan
     - Need for additional testing or referral

Documentation Requirements:
- Test type and indication
- Results
- Date/time performed
- Staff performing test
- Provider review and follow-up actions

Compliance and Monitoring:

- Routine quality checks
- Competency assessments
- CLIA documentation compliance

## MS 630B POINT-OF-CARE TESTING CLINICAL PROTOCOL (SYMPTOM CRITERIA)

### I. PURPOSE

To define standardized clinical criteria for when POCT is appropriate based on patient symptoms and presentation.

### II. GENERAL PRINCIPLES

- POCT must be based on clinical indication
- Testing should support timely diagnosis and treatment
- Unnecessary testing must be avoided

### III. SYMPTOM-BASED TESTING CRITERIA

- Urinalysis Indications:
    - Dysuria
    - Urinary frequency or urgency
    - Suspected urinary tract infection
    - Foul Odor in urine
    - Flank Pain
    - Hematuria
    - Fever
    - Fatigue
    - Confusion

- Blood Glucose Testing Indications:
    - Rapid Heartbeat
    - Shaking
    - Sweating
    - Nervousness or Anxiety
    - Irritability or confusion, Altered Mental Status
    - Dizziness
    - Hunger
    - Frequency in urination
    - Unquenchable thirst
    - Unintentional Weight Loss
    - Numbness or tingling in hands or feet
    - Very tired
    - Dry Skin
    - Slow healing wounds
    - Known diabetes with symptoms

- Pregnancy Testing Indications:
    - Missed period
    - Suspected pregnancy
    - Abdominal pain in reproductive-age patients
    - Tender or swollen breasts/nipples
    - Fatigue
    - Headaches
    - Nausea/Vomiting
    - Food Cravings or Aversions
    - Mood Swings
    - Frequency in urination

- Respiratory Testing (e.g., COVID-19, Influenza) Indications:
    - Fever
    - Cough
    - Sore throat
    - Shortness of breath
    - Fatigue
    - Muscles or Body Aches
    - Headache
    - New loss of taste or smell
    - Congestion/Runny nose
    - Nausea/Vomiting
    - Diarrhea

**IV. TEST APPROPRIATENESS REQUIREMENT**

- Testing must be supported by clinical symptoms or indication
- Routine or screening use without indication is not permitted unless specified in another protocol

**V. ESCALATION CRITERIA**

- Provider review required for:
    - Positive test results
    - Abnormal findings
    - Inconsistent clinical presentation

**VI. AUTHORITY AND STANDING ORDERS**

- This protocol is approved by the Medical Director of Native Americans for Community Action, Inc. (NACA)
- Standing orders may authorize:  Nursing staff and qualified personnel to perform POCT when criteria are met
- Staff may:

    - Identify eligible patients
    - Perform tests
    - Document results
- Providers must review abnormal or positive results

**VII. DOCUMENTATION REQUIREMENTS**

- Clinical indication for testing
- Result and interpretation
- Follow-up actions taken

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| **POLICY: MS 650** | (X) Revision<br>( ) New | Original Issue Date: 03/04/24<br>Revised Date: 03/08/24; 07/12/24<br>Approved by: Board of Directors<br>Approval Date: 03/20/24; 07/17/24; 06/11/25<br>Effective Date: 03/21/24; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |
| **Student and Volunteer Observers** | Author: Medical Staff Committee | |

**I. POLICY:** A patient consent policy for students and volunteer observers is essential to ensure that all individuals involved in observing medical procedures or interacting with patients understand the importance of patient privacy and consent.

**II. PURPOSE:** This policy is designed to ensure the protection of patient privacy and rights while providing educational opportunities for students and volunteer observers in a healthcare setting.

**III. PROCEDURES:**

- Student Types Include but Are Not Limited To:
  - Pre-Medical
  - Medical
  - Clerkship
  - Nursing
  - Interns
  - Allied Health

- Consent Form
  - All students and volunteer observers must sign a consent form before participating in any activities that involve interacting with patients or observing medical procedures. The consent form should clearly outline the nature of the activities and the expectations regarding patient privacy and confidentiality.

- Patient Privacy:
  - Students and volunteer observers must respect patient privacy at all times. This includes maintaining confidentiality regarding patient information and refraining from discussing patient cases outside of educational settings. All students and volunteers must complete a HIPAA training prior to engaging in any patient care or observation activities.
  - Students and observers may only access the minimum necessary patient information required for their role and must be supervised at all times.

- Informed Consent:
  - Before interacting with any patients, students and volunteer observers must be informed about the patient's consent status. They should not engage with patients who have not provided consent for student or observer involvement in their care.

- Professional Conduct:
  - Students and volunteer observers are expected to always conduct themselves in a professional manner. This includes adhering to the facility's dress code, following instructions from supervising healthcare professionals, and demonstrating respect for patients and staff.

- Supervision:
  - All activities involving students and volunteer observers must be supervised by qualified healthcare professionals. The supervising professionals are responsible for ensuring that patient comfort, safety, and dignity are maintained throughout the educational experience.

- Training and Orientation:
  - Prior to interacting with patients, students and volunteer observers must undergo appropriate training and orientation to familiarize themselves with the healthcare facility's policies, procedures, and expectations.

- Documentation:
  - Records of student and volunteer observer participation, including consent forms and any relevant training documentation, should be maintained in accordance with the NACA's record-keeping requirements.

- Compliance:
  - Failure to adhere to this policy may result in the restriction or termination of a student's or volunteer observer's participation in educational activities within NACA.

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| **POLICY: MS 660** | (X) Revision<br>( ) New | Original Issue Date: 03/04/24<br>Revised Date: 03/08/24; 07/12/24<br>Approved by: Board of Directors<br>Approval Date: 03/20/24; 07/17/24; 06/11/25<br>Effective Date: 03/21/24; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |
| **Provider Presence in Primary Care Setting** | Author: Medical Staff Committee | |

**I. POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to promote patient safety and well-being by ensuring that appropriate medical expertise is readily available to address unforeseen medical emergencies.

**II. PURPOSE:** The purpose of this policy is to ensure that a provider qualified to address medical emergencies is present whenever patients are receiving care in a primary care setting.

**III. STANDARDS OF CARE:**

- A provider qualified to address medical emergencies must be physically present in the primary care setting whenever patients are receiving medical care.

- Provider availability may include:
    - Onsite Presence, OR
    - Immediate availability via telehealth or remote communication

- The presence of a qualified provider is required during all hours when patient medical care is provided in the primary care setting, including regular business hours, after-hours, weekends, and holidays.

- If a qualified provider needs to be temporarily absent from the primary care setting (e.g., for personal breaks, meetings, or other reasons), arrangements must be made to ensure that another qualified provider is available to address medical emergencies in the provider's absence.

- The primary care setting must establish and maintain clear protocols and procedures for responding to medical emergencies, including the activation of emergency medical services, if necessary. These protocols should be regularly reviewed, updated, and communicated to all healthcare staff working in the setting.

- Compliance with this policy will be monitored through regular audits, checks, and staff training to ensure that a qualified provider is consistently present when patients are receiving care.

- Clinical Staff may contact the provider for:

    - Triage Support

- Review of Abnormal findings
- Urgent clinical decisions

- Any deviations or non-compliance with this policy must be promptly reported to the appropriate administrative or clinical leadership for review and corrective action.

**MS660A ESCALATION PROTOCOL (CRITICAL)**

ESCALATION PROTOCOL:

Clinical staff must escalate to a provider immediately when:

- Patients present with:
  - Emergent symptoms (e.g., chest pain, shortness of breath, altered mental status)
  - Unstable vital signs
  - Significant clinical concern or deterioration
- Escalation process:
  - Notify on-site provider immediately (if present)
  - If no on-site provider: Contact telehealth/remote provider without delay
  - If provider is not immediately available: Activate emergency response (e.g., EMS/911) as appropriate.
- Documentation of escalation must include:
  - Time of escalation
  - Provider contacted
  - Actions taken

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| **POLICY: MS 670** | (X) Revision<br>( ) New | Original Issue Date: 03/04/24<br>Revised Date: 03/08/24; 07/12/24<br>Approved by: Board of Directors<br>Approval Date: 03/20/24; 07/17/24; 06/11/25<br>Effective Date: 03/21/24; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |
| **Clinical Care Area Access** | Author: Medical Staff Committee | |

**I. POLICY**

It is the policy of Native Americans for Community Action, inc. (NACA) to regulate and control access to patient care areas, medication and vaccine rooms, and point-of-care laboratory spaces to ensure the safety, security, confidentiality, and integrity of patient care services, medications, vaccines, and laboratory operations.

**II. PURPOSE**

This policy establishes standardized access controls to:

- Protect patient privacy and safety
- Prevent unauthorized access to medications, vaccines, and laboratory materials
- Ensure compliance with clinical, regulatory, and infection control requirements
- Maintain secure and appropriate operational environments for care delivery and diagnostics.

**III. SCOPE**

This policy applies to:

- All employees, medical staff, contractors, students, and volunteers
- All patient care areas, medication/vaccine rooms, and point-of-care laboratory spaces

**IV. DEFINITIONS**

- Authorized Personnel: Individuals granted access based on job duties and approval
- Restricted Areas: Patient care areas, medication/vaccine rooms, and laboratory areas requiring controlled access
- Non-Medical Personnel: Staff without clinical roles requiring routine access to medication or laboratory spaces

**V. GENERAL ACCESS PRINCIPLES**

- Authorized Access
    - Access to all covered areas is limited to authorized personnel only based on job responsibilities and need to perform duties.
    - Access must reflect the minimum necessary standard for task completion.
- Identification and Badging
    - All authorized personnel must display identification badges at all times.
    - Access may be controlled through badge-enabled systems where applicable.
- Visitor and Non-Staff Access
    - Visitors must obtain visitor badges/passes prior to entry.

- Visitors and non-authorized individuals must be escorted at all times.

## VI. PATIENT CARE AREA ACCESS

- Access Restrictions
  - Only authorized personnel may enter patient care areas.
  - Access is limited based on:
    - Patient consent
    - Patient condition
    - Treatment requirements
    - Infection control protocols
- Visitor Requirements
  - Visitors must comply with:
    - Infection control policies
    - Privacy requirements
    - Organizational rules governing visitation
- Security Measures
  - Security may include:
    - Controlled entry systems
    - Surveillance monitoring
- These measures support patient and staff safety.

## VII. MEDICATION AND VACCINE ROOM ACCESS

- Access Control
  - Access is restricted to authorized medical personnel only.
  - Rooms must remain secured (locked) at all times when not in active use.
- Badge and Key Management
  - Access is granted via badge or controlled entry, managed through appropriate administrative oversight (e.g., HR).
- Non-Medical Personnel Access
  - Non-medical personnel may only enter with:
    - Explicit approval from leadership (e.g., CEO, Medical Director, Director of Operations, or Clinical RN)
    - Direct supervision by authorized medical staff

## VIII. POINT-OF-CARE LABORATORY ACCESS

- Access Control
  - Access is restricted to authorized medical personnel only.
- Entry Requirements
  - Badge-controlled entry systems must be used where available.
- Non-Medical Personnel Access
  - Permitted only:
    - With leadership approval
    - When accompanied by authorized clinical staff

## IX. ESCORT AND SUPERVISION REQUIREMENTS

- All non-authorized individuals (visitors, vendors, non-medical staff) must:
  - Be escorted continuously
  - Remain within the scope of approved access
- Authorized staff are responsible for direct supervision and accountability

## X. INFECTION CONTROL STANDARDS

- Access to clinical areas at Native Americans for Community Action, Inc. (NACA) must support compliance with infection prevention and control practices.
- Staff must ensure that individuals entering clinical areas comply with infection control requirements appropriate to the setting and patient condition.
- All staff, patients, visitors, and authorized personnel must adhere to:
  - Standard precautions
  - Hand hygiene requirements
  - Use of personal protective equipment (PPE) when indicated
  - Access to restricted or clinical areas may be limited during:
    - Infectious disease outbreaks
    - Exposure events
    - Situations requiring isolation or transmission-based precautions
    - Infection control practices must align with current CDC guidelines.

## XI. COMPLIANCE AND ENFORCEMENT

A. Staff Responsibilities

- All personnel must:
  - Follow access restrictions
  - Report unauthorized access or suspicious behavior immediately

B. Violations

- Violations may result in:
  - Disciplinary action
  - Revocation of access privileges
  - Further administrative or legal action as appropriate

## XII. SECURITY AND MONITORING

- The organization may implement:
  - Electronic access logs
  - Surveillance systems
  - Routine audits
- Monitoring ensures compliance and risk mitigation

## XIII. REVIEW AND REVISION

- This policy will be reviewed annually and updated as needed to maintain compliance with:
  - Regulatory requirements
  - Organizational standards
  - Patient safety best practices

**XIIII. REFERENCES:**

- Centers for Disease Control and Prevention (CDC) Infection Control Guidelines
- AAAHC Standards
- MS 200 Clinical Governance Policy

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| **POLICY: MS 680** | ( ) Revision<br>(X) New | Original Issue Date: 02/03/25<br>Revised Date:<br>Approved by: Board of Directors<br>Approval Date: 02/19/25; 06/11/25<br>Effective Date: 02/20/25; 06/12/25<br>Annual Review Date: 06/11/25 |
| **Policy and Standing Order for Routine Depression Screening in Patients Aged 8 and Older** | Author: Medical Staff Committee | |

**I. POLICY:** It is the policy of Native Americans for Community Action (NACA) to ensure the early detection and management of depression, promote mental health awareness, and enhance the overall wellbeing of patients.

**II. PURPOSE:** The purpose of this policy is to establish a standardized approach for the routine screening of depression in patients aged 8 and older within our healthcare setting. Recognizing the critical importance of early identification and management of depression, this policy aims to promote the mental health and wellbeing of our patients by utilizing validated screening tools, facilitating appropriate referrals, and ensuring timely interventions for those at risk.

**III. SCOPE:** This policy applies to healthcare professionals who interact and care for patients older than 8 years old who may be at risk for depression.

**IV. DEFINITIONS:**

| TERM | DEFINITION |
|---|---|
| PHQ 9 and PHQ 9 (modified) Screening: | A screening tool designed to assess the presence and severity of depression in individuals. It consists of nine questions that correspond to diagnostic criteria for depressive disorders as outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). |
| Positive Score | A positive score indicates that the individual has reported symptoms consistent with depression that may warrant further evaluation or intervention. |
| Mental Health Provider | A licensed provider who works in various capacities to diagnose, treat, and offer care to individuals suffering from mental illnesses and disorders and provide services for the purpose of improving an individual's mental health. |
| Warm Hand-off | A smooth and supportive transition of a patient from one healthcare professional to another that involves communication between providers to facilitate a more personal and engaging transfer of information. May occur in the presence of the patient. |
| Nursing Support Staff | Healthcare professionals such a Registered Nurses (RNs), Certified Medical Assistants (CMAs), and Health Technicians. |
| Healthcare Provider | An independently licensed individual who delivers medical services, treatments, and care to patients such as physicians, nurse practitioners, and physical assistants. |

## V. STANDARDS OF CARE:

- Routine Screening:
  - Patients aged 8 and older will be screened for depression at every clinical visit.
  - The PHQ 9 or its modified version will be the primary screening tool used unless otherwise specified by the provider. Only validated tools can be utilized in accordance with clinical guidelines.

- Review of Screening Scores:
  - The healthcare provider will review the screening results with the patient during the visit including the significance of the score, options for treatment or mental health providers.
  - PHQ 9 score Interpretation:
    - 0-4: None-minimal depression
    - 5-9: Mild depression
    - 10-14: Moderate depression
    - 15-19: Moderately severe depression
    - 20-27: Severe depression
  - Scores indicate varying levels of severity and increasing levels of concern regarding the individual's mental health.
  - All positive screening results must be evaluated by a provider.
  - Scores of 15 or higher will indicate a potential risk for depression and necessitate a referral to behavioral health services, contingent upon obtaining consent from the patient or their guardian.

- Referral Process:
  - For scores of 15 or higher, the provider will discuss the need for referral to behavioral health services with the patient or guardian and obtain informed consent, especially if individual expresses significant distress or impairment in daily functioning.
  - Nursing support staff are authorized to initiate referrals for positive screening scores (15 or higher) without requiring a written order, under a standing order that the medical provider will authenticate provided patient consent is obtained.
  - All referrals will be made in a timely manner, ideally within 24 hours, and documented in the patient's electronic health record, including screening results and communication with behavioral or mental health professionals.
  - Care must be coordinated with behavioral health services when indicated.
  - Warm handoffs must be utilized whenever possible to ensure continuity of behavioral health care.

- Immediate Intervention for Suicidal Ideation:
  - If a patient expresses suicidal ideation during screening or any healthcare interaction, immediate intervention is required.
  - The provider must promptly notify the onsite Behavioral Health Director or their designee.
  - If the Behavioral Health Director or designee is unavailable, the provider will contact the local crisis unit, crisis hotline, or crisis text line for urgent support.
  - Documentation of the risk assessment, situation, actions taken, safety plan, and outcomes will be recorded in the patient's electronic health record, emphasizing the urgency of the

situation.

**VI. Documentation and Communication:**

- All screening results, referrals made, and communications with behavioral or mental health providers must be thoroughly documented in the patient's medical record.
- The urgency of the referral and follow-up actions taken should be clearly indicated.
- When a warm handoff occurs, documentation must include:
    - Behavioral Health Staff involved
    - Time and method of handoff
    - Patient acceptance or refusal
    - Immediate Actions Taken
- Training and Compliance:
    - All relevant staff will receive training on the administration of the PHQ 9 tool, referral procedures, and appropriate responses to the suicidal ideation.
    - Non-compliance of this policy may result in disciplinary action up to and including termination.
- Review and Revision:
    - This policy will be reviewed annually and revised as necessary to ensure alignment with best practices, regulatory requirements, and the evolving needs of our patient population.

## MS 680A – DEPRESSION SCREENING PROCEDURE

1. Screening
    - Patients are screened using validated tools (e.g., PHQ-2, PHQ-9)
    - Screening occurs:
        - At all office visits (excluding non-provider visits)
        - When clinically indicated

2. Scoring and Initial Action
    - Staff score and document results
    - Positive screens are flagged for provider review

3. Provider Evaluation
    - Provider assesses:
        - Severity of symptoms
        - Functional impact
        - Risk factors, including suicide risk

4. Care Coordination
    - Referral to behavioral health when indicated
    - Warm handoff performed when possible

5. Follow-Up
    - Follow-up visits scheduled based on severity
    - Monitoring for symptom progression or improvement

Documentation Requirements
- Screening results
    - Provider assessment
    - Referrals and follow-up actions
    - Warm handoff, if completed

Compliance and monitoring
- Review of depression screening rates
- Monitoring of referral completion
- Chart audits for documentation completeness

**MS 680B – DEPRESSION & SUICIDE RISK CLINICAL PROTOCOL**

**I. PURPOSE:** To establish standardized criteria for depression screening, suicide risk assessment, and appropriate intervention.

**II. SCREENING CRITERIA**

- All patients must be screened using a validated tool (e.g., PHQ-2 or PHQ-9)
- Positive screening results require further evaluation

**III. SUICIDE RISK IDENTIFICATION (REQUIRED)**

Suicide risk assessment must be performed when:

- PHQ-9 indicates risk (e.g., suicidal ideation)
- Patient expresses thoughts of self-harm
- Behavioral health concerns are identified

**IV. SUICIDE RISK PATHWAY**

- LOW RISK
  - No active ideation or plan
  - Provide education and follow-up
  - Behavioral health referral as appropriate

- MODERATE RISK
  - Suicidal thoughts without plan or intent
  - Immediate provider evaluation required
  - Warm handoff to behavioral health strongly recommended
  - Safety plan initiated
  - Close follow-up arranged

- HIGH RISK (EMERGENT**)**
  - Suicidal ideation with plan or intent
  - Do NOT leave patient unattended
  - Immediate provider involvement required
  - Activate emergency response (crisis services)
  - Ensure safe transfer to higher level of care

**V. WARM HANDOFF REQUIREMENT**

- When behavioral health services are indicated:
  - warm handoff should be performed whenever possible
  - This involves direct, real-time transfer of care from medical provider to behavioral health staff
- If warm handoff is not possible:
  - Referral must be expedited

- Follow-up must be ensured

## VI. ESCALATION CRITERIA

- Immediate escalation required for:
  - Any suicidal ideation
  - Behavioral escalation or distress
  - Acute mental health crisis

## VII. AUTHORITY AND SCOPE

- This protocol is approved by the Medical Director of Native Americans for Community Action, Inc. (NACA)
- Staff may:
  - Perform screening tools
  - Identify positive results
  - Initiate referrals
- Providers must:
  - Assess suicide risk
  - Make clinical decisions
  - Determine disposition of care

## VIII. DOCUMENTATION REQUIREMENTS

- Screening tool and score
- Suicide risk assessment findings
- Risk level (low, moderate, high)
- Interventions taken
- Warm handoff (if performed)
- Follow-up plan

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| **POLICY: MS 700** | (X) Revision<br>( ) New | Original Issue Date: 05/31/12<br>Revised Date: 09/03/20; 07/12/24; 11/11/24 |
| **Patient Discharge or Refused Care from Practice** | Author: Medical Staff Committee | Approved by: Board of Directors<br>Approval Date: 09/16/20; 07/17/24; 11/20/24; 06/11/25<br>Effective Date: 09/17/20; 07/18/24; 12/02/24; 06/12/25<br>Annual Review Date: 06/11/25 |

**I. POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to ensure that patient discharge from care is conducted in a safe, appropriate, and ethically responsible manner, with clear communication, continuity of care, and compliance with professional standards. Patients shall not be discharged in a manner that results in abandonment or interruption of necessary medical care.

**II. PURPOSE:** To establish standardized criteria and processes for patient discharge, ensuring patient safety, continuity of care, and compliance with regulatory and ethical requirements.

**III. SCOPE:** Applies to all providers and clinical staff responsible for patient care and discharge decisions at NACA.

**IV. GOVERNANCE**: All discharge decisions and processes are governed by the Medical Director in accordance with MS 200 Clinical Governance and are subject to periodic review.

**V. DISCHARGE CRITERIA:**

- Patients may be discharged from care when one or more of the following criteria are met:
    - The patient's condition has resolved or no longer requires active treatment
    - The patient has achieved treatment goals or maximum clinical benefit
    - The patient is stable and appropriate for self-management or external care
    - The patient requires a higher level of care and is appropriately transferred
    - The patient voluntarily withdraws from care
    - The patient repeatedly fails to adhere to treatment plans despite documented efforts to engage and support compliance.
- All discharge decisions must be:
    - Clinically appropriate
    - Documented with clear rationale
    - Communicated to the patient

**VI. ABANDONMENT PROHIBITION**

- NACA prohibits patient abandonment under all circumstances.
- Patients must be provided with:
    - Notice of discharge
    - Reason for discharge (as appropriate)

- Information on alternative care options or referrals
- Adequate time to secure alternative care
- Emergency care must not be denied during the transition period

## VII. CARE TRANSITION REQUIREMENTS

- Discharge planning must include:
- Follow-up instructions
- Medication guidance (if applicable)
- Referrals to other providers or services when needed
- Continuity of care must be ensured through:
- Coordination with receiving providers
- Transfer of relevant clinical information

## VIII. PATIENT COMMUNICATION

- Discharge decisions must be clearly communicated to the patient
- Patients must receive instructions in a manner that supports understanding (health literacy principles)
- Interpreter services must be used when necessary

## IX. DOCUMENTATION REQUIREMENTS

- The following must be documented in the Electronic Health Record (EHR):
    - Clinical reason for discharge
    - Patient condition at time of discharge
    - Instructions provided to the patient
    - Referrals or follow-up arrangements
    - Patient understanding and response (when applicable)

## X. COMPLIANCE AND MONITORING

- Compliance is monitored through:
    - Chart audits of discharge documentation
    - Review of continuity of care and follow-up processes
    - Evaluation of patient safety outcomes

## XI. REFERENCES

- AAAHC Standards for Patient Rights and Continuity of Care
- MS 200 Clinical Governance Policy

APPENDIX I

(Date)

(Patient Name)
(Patient
Address)
(Patient City, State, Zip Code)

RE: Discharge from services at NACA Family Health

Center Dear (Patient Name):

This notice is to inform you that I must withdraw from rendering further professional services for you through the NACA Family Health Center because ---

Your condition may require additional medical attention. I recommend you place yourself under the care of another medical provider without delay. If you wish, the NACA Family Health Center shall be available to you for medical care not to exceed 30 days from the date of this letter. This will give you ample time to select a medical provider of your choice from the many competent providers in the Flagstaff area. With your written approval, NACA will make available to this provider any medical records from your care at the NACA Family Health Center.

You have the right to appeal this decision within 30 days – see the attached Patient/Client Grievance policy. If a response is not received from you within 30 days, I will proceed with discharging you from services at the Family Health Center.

Sincerely,

(Signature)
Medical
Director

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| **POLICY: MS 710** | (X) Revision<br>( ) New | Original Issue Date: 03/04/24<br>Revised Date: 03/08/24; 07/12/24<br>Approved by: Board of Directors<br>Approval Date: 03/20/24; 07/17/24; 06/11/25<br>Effective Date: 03/21/24; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |
| **Patient Education** | Author: Medical Staff Committee | |

I. **POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to provide patient education that is clear, culturally responsive, and tailored to individual patient needs to support understanding, informed decision-making, and self-management of health conditions.

II. **PURPOSE:** To establish standardized expectations for the delivery and documentation of patient education, ensuring patients understand their health conditions and care plans.

III. **SCOPE**: Applies to all clinical staff providing patient education at NACA.

IV. **GOVERNANCE:** Patient education practices are approved by the Medical Director and reviewed annually in accordance with MS 200 Clinical Governance.

**V. STANDARDS OF CARE**

- Patient education must be incorporated into all appropriate clinical encounters
- Education must be:
- Clear and understandable
- Delivered using plain language
- Culturally and linguistically appropriate
- Education should address:
- Diagnosis and condition
- Treatment options
- Medication use
- Preventive care and self-management
- Staff should adapt education to:
- Health literacy level
- Cultural and language needs
- Patient preferences

**VI. TEACH-BACK REQUIREMENT**

- The teach-back method should be used when appropriate to confirm patient understanding.
- Teach-back involves asking the patient to explain information in their own words to verify comprehension.
- Staff must re-educate patients when gaps in understanding are identified.

## VII. DOCUMENTATION REQUIREMENTS

The following must be documented in the Electronic Health Record (EHR):

- Topic(s) of education provided
- Educational materials or instructions given
- Patient understanding and response
- Any identified barriers to understanding
- Follow-up education plans if needed

## VIII. TEACH-BACK DOCUMENTATION:

- Documentation must indicate when the teach-back method is used (e.g., "teach-back method used").
- Any misunderstanding identified and re-education provided must be documented.

## IX. COMPLIANCE AND MONITORING

Compliance is monitored through:

- Chart audits for documentation of patient education
- Evaluation of patient understanding and engagement

## X. REFERENCES

- AAAHC Standards for Patient Education and Communication
- MS 200 Clinical Governance Policy

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| **POLICY: MS 720** | (X) Revision<br>( ) New | Original Issue Date: 03/04/24<br>Revised Date: 03/08/24; 07/12/24; 06/02/25 |
| **Referred Care & Purchased/Referred Care (PRC) Policy** | Author: Medical Staff Committee | Approved by: Board of Directors<br>Approval Date: 03/20/24; 07/17/24; 06/11/25<br>Effective Date: 03/21/24; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |

**I. POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to ensure that all referrals and Purchased/Referred Care (PRC) services are managed in a coordinated, compliant, and patient-centered manner. All referred services must support continuity of care and meet clinical necessity.

**II. PURPOSE:** To establish standardized expectations for referral management and PRC services, ensuring appropriate utilization, regulatory compliance, and continuity of care.

**III. SCOPE:** Applies to all providers, referral coordinators, and staff involved in initiating, authorizing, and tracking referrals and PRC services at NACA.

**IV. GOVERNANCE:** All PRC and referral processes are governed by the Medical Director in accordance with MS 200 Clinical Governance.

**V. STANDARDS OF CARE**

- Referrals must be based on clinical necessity and coordinated appropriately
- Care must ensure continuity between NACA and external providers
- Referrals must be tracked to completion

**VI. IHS / PRC REQUIREMENTS:**

- Payor of Last Resort:
- PRC services are authorized only after all other third-party resources are exhausted
- Pre-Authorization (REQUIRED):
    - Non-emergent services must be authorized prior to delivery
    - Services obtained without authorization may not be covered
- Emergency Notification (72-HOUR RULE):
    - Emergency services must be reported to PRC within 72 hours
    - Failure to meet this requirement may result in denial of coverage

**VII. DOCUMENTATION REQUIREMENTS**

The following must be documented in the Electronic Health Record (EHR):

- Referral order and clinical indication
- Referral initiation date
- Referral outcome (completed, pending, canceled)

- Communication with patients and external providers

## VIII. COMPLIANCE AND MONITORING

NACA will monitor referral and PRC performance through:

- Referral completion rate
- Timeliness of referral scheduling
- PRC authorization compliance

## IX. REFERENCES

- Indian Health Service (IHS) PRC Guidelines
- AAAHC Standards
- MS 200 Clinical Governance Policy

**MS720A Referral and Care Coordination Procedure**

PURPOSE

To ensure all referrals are appropriately initiated, tracked, completed, and documented, maintaining continuity of care and timely follow-up.

RESPONSIBILITY

- Medical Providers: Initiate and review referrals
- Nursing Staff: Coordinate and track referrals through a tracking systems and support scheduling and documentation.

PROCEDURE

1. Referral Initiation
   - The licensed provider determines the need for referral based on clinical assessment.
   - The provider shall:
     - Enter referral order in the EHR
     - Include reason for referral and urgency
     - Specify specialty/service requested
   - The referral order must be communicated to appropriate staff for processing.

2. Referral Processing
   - Designated staff shall:
     - Verify patient demographic and insurance information
     - Obtain prior authorization if required
     - Schedule referral appointment or provide patient with instructions
   - The referral details shall be documented in the EHR, including:
     - Date of referral
     - Referred provider/facility
     - Appointment status (scheduled, pending, declined)

3. Referral Tracking
   - All referrals shall be entered into a tracking system or report.
   - Tracking must include:
     - Outstanding referrals
     - Scheduled appointments
     - Completed referrals
     - Overdue referrals
   - Reports shall be reviewed regularly (at minimum monthly) by designated staff.

4. Completion and Follow-Up
   - Staff shall ensure receipt of consultation reports, test results, or specialty findings.
   - Upon receipt:
     - Results shall be uploaded or documented in the EHR
     - The referring provider shall review and sign off
   - The provider shall:

- Communicate results to the patient
- Update care plan as indicated
-

5. Urgent and High-Risk Referrals
- Urgent referrals shall be:
  - Clearly identified as urgent in the EHR
  - Communicated directly to receiving provider/facility when appropriate
- Staff shall ensure expedited scheduling and follow-up.

6. Patient Communication
- Patients shall be informed of:
  - Reason for referral
  - Importance of follow-up
  - Instructions for scheduling and attendance
- Education shall be documented in the EHR.

Documentation Requirements
All steps must be documented in the EHR, including:
- Referral order
- Scheduling efforts
- Patient communication
- Receipt of consult results
- Provider review and follow-up plan

Quality Monitoring
- The organization shall monitor:
  - Referral completion rates
  - Timeliness of results
  - Follow-up compliance
- Findings shall be reviewed through Quality Improvement processes

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| **POLICY: MS 800** | (X) Revision<br>( ) New | Original Issue Date: 10/16/19<br>Revised Date: 09/03/20; 07/12/24<br>Approved by: Board of Directors<br>Approval Date: 09/16/20; 07/17/24; 06/11/25<br>Effective Date: 09/17/20; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |
| **Management of Medical Sharps** | Author: Medical Staff Committee | |

**I. POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to ensure the safe handling, use, and disposal of sharps and to prevent occupational exposure to bloodborne pathogens through adherence to established infection control and safety practices. All staff must follow approved procedures to minimize risk of injury and exposure.

**II. PURPOSE:** To establish standardized safety practices for sharps handling and exposure response to protect patients and staff and ensure compliance with CDC and OSHA guidelines.

**III. SCOPE:** Applies to all clinical staff, support staff, students, and contractors who may handle sharps or be exposed to blood or body fluids at NACA.

**IV. GOVERNANCE:** Sharps safety practices and exposure protocols are approved by the Medical Director and reviewed annually in accordance with MS 200 Clinical Governance. This policy aligns with CDC infection control guidelines and OSHA Bloodborne Pathogens Standard.

**V. STANDARDS OF CARE**

- All sharps must be handled with extreme caution to prevent injury
- Needles must never be recapped, bent, or removed manually unless required by specific device design
- Sharps must be disposed of immediately after use in approved sharps containers
- Standard precautions must be followed at all times, including:
    - Hand hygiene
    - Use of personal protective equipment (PPE)
    - Safe handling of blood and body fluids
- Engineering controls (e.g., safety devices) must be used when available
- Staff must be trained in sharps safety and exposure response

**VI. INFECTION CONTROL ALIGNMENT**

- Sharps handling and exposure prevention must align with current CDC infection prevention and control guidelines, including standard precautions and bloodborne pathogen safety practices.

**MS800A SHARPS SAFETY PROCEDURE**

1. Safe Handling
   - Use safety-engineered devices when available
   - Do not recap or manipulate needles after use
   - Keep sharps in view during use

2. Disposal
   - Dispose of sharps immediately after use
   - Use approved sharps containers located in clinical areas
   - Do not overfill containers (follow fill line)

3. Environmental Safety
   - Ensure sharps containers are:
     - Accessible
     - Properly mounted
     - Replaced when full

4. Staff Responsibilities
   - All staff must adhere to sharps safety practices
   - Report any hazards (overfilled containers, improper storage) immediately

DOCUMENTATION REQUIREMENTS
   - Any safety issues or incidents must be documented

COMPLIANCE AND MONITORING
   - Routine safety audits
   - Monitoring of sharps container use
   - Staff training and competency validation

**MS800B EXPOSURE CONTROL PROTOCOL**

## I. PURPOSE

To provide a standardized response to sharps injuries and exposure to blood or body fluids.

## II. EXPOSURE TYPES

Exposure includes:

- Needle stick injury
- Cut from sharp object
- Contact with blood/body fluids via:
    - Broken skin
    - Mucous membranes (eyes, mouth)

## III. IMMEDIATE RESPONSE

1. Perform immediate first aid:
    - Wash needlestick or cut with soap and water
    - Flush eyes or mucous membranes with water or saline
2. Report exposure immediately to supervisor and Quality Improvement Compliance Director
3. Notify provider or designated clinical lead

## IV. CLINICAL FOLLOW-UP

- Exposure must be evaluated promptly
- Assess:
    - Type of exposure
    - Source patient risk (if known)
    - Employee health status
- Initiate post-exposure prophylaxis (PEP) when indicated
- Follow CDC guidance for testing and treatment

## V. REPORTING REQUIREMENTS

- All exposures must be reported immediately
- Incident report must be completed

## VI. FOLLOW-UP CARE

- Baseline and follow-up testing per CDC guidelines
- Counseling and support provided to exposed staff
- Monitoring for signs of infection

## VII. AUTHORITY AND SCOPE

- This protocol is approved by the Medical Director of NACA
- All staff are required to follow exposure response procedures
- Medical Director oversees clinical evaluation and management

## VIII. DOCUMENTATION REQUIREMENTS

- Exposure details (date, time, type)
- Actions taken immediately after exposure
- Clinical evaluation and follow-up
- Reporting and notifications

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| **POLICY: MS 900** | (X) Revision<br>( ) New | Original Issue Date: 08/27/19<br>Revised Date: 09/03/20; 07/12/24<br>Approved by: Board of Directors<br>Approval Date: 09/16/20; 07/17/24; 06/11/25<br>Effective Date: 09/17/20; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |
| **Expedited Partner Therapy for Sexually Transmitted Infections** | Author: Medical Staff Committee | |

**I. POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to provide Expedited Partner Therapy (EPT) for the treatment of sexually transmitted infections (STIs) in accordance with CDC recommendations and applicable state laws. EPT is utilized to reduce reinfection rates, interrupt disease transmission, and improve patient and community health outcomes when sexual partners are unable or unlikely to seek timely medical evaluation.

**II. PURPOSE:** To establish standardized expectations for the safe prescribing, dispensing, and documentation of EPT to ensure effective treatment of partners and prevention of STI reinfection.

**III. SCOPE:** Applies to all licensed providers involved in STI diagnosis, treatment, and partner management at NACA.

**IV. GOVERNANCE:** EPT practices are approved by the Medical Director and reviewed annually in accordance with MS 200 Clinical Governance and CDC STI Treatment Guidelines. All prescribing must comply with state law and professional scope of practice.

**V. STANDARDS OF CARE**

- EPT must be offered when clinically appropriate for eligible STIs
- Patients must receive education regarding partner treatment
- Providers must ensure prescriptions are safe and appropriate
- Documentation must clearly indicate EPT use
- EPT must be used only when:
    - Partner is unlikely to seek timely care
    - No contraindications are identified

**VI. DOCUMENTATION REQUIREMENTS**

The following must be documented in the Electronic Health Record (EHR):

- STI diagnosis
- EPT offered and accepted or declined
- Medication provided or prescribed for partner(s)
- Patient education provided
- Any known contraindications or concerns

**VII. COMPLIANCE AND MONITORING**

- Monitoring of EPT utilization rates
- Chart audits for documentation completeness
- Review of STI reinfection rates

## VIII. REFERENCES

- CDC Sexually Transmitted Infection Treatment Guidelines
- AAAHC Standards
- MS 200 Clinical Governance Policy

**MS 900A – EXPEDITED PARTNER THERAPY (EPT) PROCEDURE**

1. Identification of Eligible Patient
   - Patient is diagnosed with a qualifying STI (e.g., chlamydia, gonorrhea)

2. Assessment for EPT Eligibility
   - Provider determines:
     - Likelihood partner will seek care
     - Absence of known contraindications (e.g., allergies)

3. Offer of EPT
   - EPT is offered to the patient for their partner(s)
   - Patient is informed about:
     - Purpose of EPT
     - Importance of partner treatment
     - Risks and limitations

4. Prescription / Medication Provision
   - Provider:
     - Prescribes medication for partner(s)
     - Prescription may be written in accordance with state allowances for unnamed partners

5. Patient Education
   - Patient receives instructions to provide to partner(s), including:
     - Medication use
     - Possible side effects
     - Need for full STI evaluation and testing

6. Documentation
   - Document:
     - EPT offered and accepted/declined
     - Medication provided/prescribed
     - Education provided

7. Follow-Up
   - Encourage patient follow-up testing as appropriate
   - Reinforcement of prevention and safe practices

COMPLIANCE AND MONITORING
- Review of EPT documentation
- Monitoring adherence to prescribing standards

**MS900B EPT CLINICAL PROTOCOL**

**I. PURPOSE:** To define clinical criteria and safe prescribing practices for Expedited Partner Therapy in STI management.

**II. ELIGIBLE CONDITIONS**

- EPT is appropriate for:
  - Chlamydia
  - Gonorrhea (when permitted by law and clinically appropriate)

- EPT is not routinely recommended for:
  - Syphilis
  - HIV
  - Complicated infections

**III. ELIGIBILITY CRITERIA**

- EPT may be used when:
  - Patient has confirmed or suspected STI
  - Partner(s) are unlikely to seek timely care
  - No known allergies or contraindications are reported

**IV. CONTRAINDICATIONS**

- Do NOT use EPT when:
  - Partner has known medication allergy
  - Symptoms suggest complicated infection
  - Patient cannot provide adequate partner information

**V. MEDICATION GUIDANCE**

- Treatment must follow CDC-recommended regimens
- Provide appropriate dosing instructions
- Ensure patient can convey instructions to partner(s)

**VI. PATIENT & PARTNER EDUCATION**

- Patients must be instructed to inform partners:
  - Take medication as directed
  - Seek full STI evaluation and testing
  - Avoid sexual activity until treatment is complete

**VII. ESCALATION CRITERIA**

- Provider consultation required if:
  - Complicated STI suspected
  - Pregnancy concerns
  - Treatment failure or reinfection

## VIII. AUTHORITY AND SCOPE

- This protocol is approved by the Medical Director of NACA
- Only licensed providers may prescribe EPT medications
- Nursing staff may support education and documentation

## IX. DOCUMENTATION REQUIREMENTS

- STI diagnosis
- Eligibility for EPT
- Medication prescribed or dispensed
- Education provided
- Any identified risks or contraindications

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| **POLICY: MS 920** | (X) Revision<br>( ) New | Original Issue Date: 03/04/24<br>Revised Date: 03/08/24; 07/12/24<br>Approved by: Board of Directors<br>Approval Date: 03/20/24; 07/17/24; 06/11/25<br>Effective Date: 03/21/24; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |
| **Nurse Competency** | Author: Medical Staff Committee | |

I. **POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to ensure that all nursing staff demonstrate and maintain clinical competency necessary to provide safe, effective, and high-quality patient care. Competencies must be validated initially and assessed periodically to ensure continued proficiency and alignment with evidence-based practice and organizational standards.

II. **PURPOSE:** To establish standardized expectations for the evaluation, validation, and maintenance of nursing competencies to promote patient safety, regulatory compliance, and quality of care.

III. **SCOPE:** Applies to all nursing staff providing clinical services at NACA, including Registered Nurses (RNs), Certified Medical Assistants (CMAs) and other licensed nursing personnel.

IV. **GOVERNANCE:** Nursing competency requirements are overseen by the Medical Director and nursing leadership in accordance with MS 200 Clinical Governance. Competency standards are reviewed annually and updated as needed to reflect current clinical practices and organizational requirements.

V. **STANDARDS OF CARE**

- All nursing staff must perform duties within:
    - Scope of practice
    - Verified competency
    - Approved protocols and standing orders

- Competency validation must include:
    - Clinical skills
    - Knowledge-based assessment
    - Safe use of equipment and procedures

- Competency is required prior to:
    - Independent performance of clinical tasks
    - Participation in new procedures or services

- Ongoing education and training must be provided to maintain competency

- Staff must demonstrate competency in:

    - Infection control practices

- Medication administration
- Emergency response
- Use of clinical protocols and standing orders

## VI. DOCUMENTATION REQUIREMENTS

The following must be documented and maintained:

- Initial competency validation records
- Ongoing competency assessments
- Training completion records
- Skills checklists and evaluations
- Remediation or retraining activities (if needed)

Documentation must be maintained in accordance with NACA policies and available for audit.

## VII. COMPLIANCE AND MONITORING

Compliance is monitored through:

- Periodic review of competency records
- Observation of clinical practices
- Chart audits and performance evaluations
- Review of incidents related to competency gaps

## VIII. REFERENCES

- AAAHC Standards for Clinical Staff Competency
- MS 200 Clinical Governance Policy
- CDC Infection Control Guidelines

**MS920A NURSING COMPETENCY PROCEDURE**

1. Initial Competency Assessment
   - Upon hire or role change:
     - Nursing staff must complete competency validation for required skills
     - Includes:
       - Skills demonstration
       - Knowledge assessment
       - Review of policies and protocols

2. Competency Validation
   - Competency may be validated through:
     - Direct observation
     - Skills checklists
     - Simulation or demonstration
     - Written or verbal assessment

3. Annual Competency Review
   - All nursing staff must undergo periodic competency reassessment (at least annually or as required)
   - Additional assessments required when:
     - New procedures are introduced
     - Performance concerns arise

4. Training and Education
   - Ongoing training is provided for:
     - Updates in clinical practice
     - New equipment or procedures
     - Regulatory requirements

5. Remediation
   - If competency gaps are identified:
     - Additional training must be provided
     - Competency must be revalidated before independent practice

6. Documentation
   - Record all competency activities, including:
     - Assessment methods
     - Results
     - Dates
     - Evaluator

7. Escalation
   - Escalate to leadership when:
     - Significant competency deficiencies are identified

- Patient safety is impacted
- Staff fail to meet required competency standards

DOCUMENTATION REQUIREMENTS

- Completed competency checklists
- Training records
- Remediation actions
- Revalidation results

COMPLIANCE AND MONITORING

- Audit of competency records
- Monitoring of staff performance
- Review of incidents related to competency issues

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| **POLICY: MS 940** | (X) Revision<br>( ) New | Original Issue Date: 03/04/24<br>Revised Date: 03/08/24; 07/12/24<br>Approved by: Board of Directors<br>Approval Date: 03/20/24; 07/17/24; 06/11/25<br>Effective Date: 03/21/24; 07/18/24; 06/12/25<br>Annual Review Date: 06/11/25 |
| **Healthcare Laboratory and Imaging Follow-up** | Author: Medical Staff Committee | |

I. **POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to ensure that all laboratory and imaging results are reviewed, communicated, and acted upon in a timely and clinically appropriate manner. NACA will maintain a reliable tracking system to prevent missed or delayed follow-up and ensure patient safety and continuity of care.

II. **PURPOSE:** To establish standardized expectations for the tracking, review, communication, and follow-up of laboratory and imaging results to reduce risk and ensure appropriate clinical action.

III. **SCOPE:** Applies to all providers, nursing staff, and clinical support staff involved in ordering, reviewing, and communicating laboratory and imaging results at NACA.

IV. **GOVERNANCE:** All laboratory and imaging follow-up processes are approved by the Medical Director and reviewed annually in accordance with MS 200 Clinical Governance.

V. **STANDARDS OF CARE:**

- All ordered laboratory and imaging tests must be tracked to completion
- RESULT REVIEW REQUIREMENT:
    - Providers are responsible for reviewing all results in a timely manner
- TIMELINESS:
    - Critical results must be addressed immediately
    - Non-critical abnormal results must be reviewed and acted upon promptly
    - Routine results must be reviewed within a reasonable timeframe (generally within 7–10 business days unless urgent)
- PATIENT NOTIFICATION:
    - Patients must be notified of results (normal and abnormal)
    - Notification method must support understanding (phone, portal, in-person)
- FOLLOW-UP ACTION:
- Abnormal results must result in:
    - Clinical action (treatment, further testing, referral), OR
    - Clear documentation of plan
- TRACKING SYSTEM:
- NACA must maintain a system to:
    - Track ordered tests
    - Confirm receipt of results

- Ensure follow-up is completed

## VI. DOCUMENTATION REQUIREMENTS

The following must be documented in the Electronic Health Record (EHR):

- Test ordered and indication
- Receipt of results
- Provider review and interpretation
- Patient notification (date, method)
- Follow-up plan or action taken
- Attempts to contact patient (if applicable)

## VII. COMPLIANCE AND MONITORING

Compliance is monitored through:

- Chart audits for result review and follow-up
- Tracking of missed or delayed results

## VIII. REFERENCES

- AAAHC Standards for Diagnostic Testing and Follow-Up
- MS 200 Clinical Governance Policy

**MS940A LABORATORY AND IMAGING FOLLOW-UP PROCEDURE**

1. Test Ordering
   - Provider orders laboratory or imaging tests in the EHR
   - Clinical indication must be documented

2. Tracking of Orders
   - All orders must be tracked using an established system (EHR or log)
   - Staff ensure:
     - Tests are completed
     - Results are received

3. Result Receipt and Routing
   - Results are routed to the ordering provider
   - Critical results must be flagged immediately

4. Provider Review
   - Provider reviews results within expected timeframes:
     - Immediate for critical
     - Prompt for abnormal
     - Routine within standard timeframe

5. Patient Notification
   - Staff notify patients of results:
     - Normal results → routine notification
     - Abnormal results → timely direct communication
   - Use:
     - Phone
     - In-person communication

6. Follow-Up Actions
   - Provider determines next steps:
     - Treatment
     - Repeat testing
     - Referral
   - All actions must be documented

7. Failed Contact / Escalation
   - If patient cannot be reached:
     - Make multiple contact attempts using available methods
     - Document all attempts in EHR
   - Escalate to provider for further action if:
     - Results are abnormal
     - Follow-up is clinically necessary

- For critical results:
    - Continue attempts until patient is reached
    - Consider emergency contact or welfare check if appropriate

8. Closing the Loop
- Ensure all results are:
    - Reviewed
    - Communicated
    - Acted upon
    - Orders are not considered complete until follow-up is documented

DOCUMENTATION REQUIREMENTS
- Order tracking status
- Result receipt and review
- Patient notification
- Follow-up actions
- Contact attempts

COMPLIANCE AND MONITORING
- Audit of closed-loop tracking (orders to follow-up)
- Monitoring for missed or delayed results
- Review of abnormal result follow-up

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| **POLICY: MS 950** | (X) Revision (<br>) New | Original Issue Date: 11/11/24<br>Revised Date:<br>Approved by: Board of Directors<br>Approval Date: 11/20/24; 06/11/25<br>Effective Date: 12/02/24; 06/12/25<br>Annual Review Date: 06/11/25 |
| **Use of Anesthetics** | Author: Medical Staff Committee | |

**I. POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to ensure the safe and appropriate use of anesthetic agents during clinical procedures, consistent with evidence-based standards and patient safety requirements. Only anesthetic practices appropriate to the outpatient setting and within staff scope of practice are permitted.

**II. PURPOSE:** To establish standardized expectations for the safe administration, monitoring, and documentation of anesthetics used in clinical procedures.

**III. SCOPE:** Applies to all providers and clinical staff involved in procedures requiring local or topical anesthetics at NACA.

**IV. GOVERNANCE:** All anesthetic use and protocols are approved by the Medical Director and reviewed annually in accordance with MS 200 Clinical Governance. Moderate and deep sedation, as well as general anesthesia, are not routinely performed unless specifically authorized and supported by appropriate resources and credentialing.

**V. STANDARDS OF CARE**

- Only approved anesthetic agents appropriate for the outpatient setting may be used
- Types of anesthetics permitted include:
    - Local anesthetics (e.g., lidocaine)
    - Topical anesthetics
- Moderate or deep sedation is not permitted without specific authorization, training, and monitoring capability
- Anesthetic use must be:
    - Clinically indicated
    - Appropriate for the procedure
    - Based on patient-specific factors
- Patient safety must include:
    - Allergy verification prior to administration
    - Dose calculation based on patient factors
    - Availability of emergency equipment and medications
    - Infection control practices must follow CDC guidance

**VI. PATIENT SAFETY REQUIREMENTS**

- Pre-procedure assessment must include:
    - Allergies

- Medical history
- Medication review

- Emergency preparedness:
  - Staff must be trained in basic life support (BLS)
  - Emergency supplies must be immediately available (e.g., epinephrine)
  - Patients must be monitored as appropriate during and after anesthetic use

## VII. DOCUMENTATION REQUIREMENTS

The following must be documented in the Electronic Health Record (EHR):

- Type of anesthetic used
- Dose and route of administration
- Site of administration
- Patient tolerance and response
- Any adverse reactions or complications

## VIII. COMPLIANCE AND MONITORING

Compliance is monitored through:

- Chart audits of procedural documentation
- Review of adverse events
- Monitoring of medication safety practices

## IX. REFERENCES

- AAAHC Standards for Procedural Safety
- CDC Infection Control Guidelines
- MS 200 Clinical Governance Policy

**MS950A ANESTHETIC ADMINISTRATION PROCEDURE**

1. Pre-Procedure Assessment
   - Verify patient identity
   - Review:
     a. Allergies (especially to anesthetics)
     b. Medical history
     c. Current medications

2. Preparation
   - Select appropriate anesthetic agent
   - Calculate safe dosage
   - Prepare equipment and medication

3. Administration
   - Administer anesthetic using appropriate technique
   - Maintain aseptic technique
   - Monitor patient response

4. Intra-Procedure Monitoring
   - Observe patient for:
     a. Adverse reactions
     b. Signs of toxicity
     c. Changes in condition

5. Post-Procedure Monitoring
   - Assess patient recovery
   - Monitor for delayed reactions
   - Provide post-procedure instructions

6. Emergency Response
   - If adverse reaction occurs:
     a. Stop administration
     b. Initiate emergency response
     c. Notify provider immediately

DOCUMENTATION REQUIREMENTS
- Pre-assessment findings
- Anesthetic type and dose
- Patient response
- Any complications

COMPLIANCE AND MONITORING
- Review of anesthesia-related documentation

- Monitoring of adverse events

## MS950B ANESTHETIC CLINICAL PROTOCOL

I. **PURPOSE:** To define safe clinical criteria for anesthetic use and prevent adverse events.

II. **APPROVED USE**

- Anesthetics may be used for:
  - Minor procedures (e.g., laceration repair, I&D)
  - Pain control for localized procedures

III. **SAFETY CRITERIA**

- Prior to administration:
  - Confirm no known allergy to anesthetic agent
  - Verify safe dose based on:
  - Patient weight (when applicable)
  - Maximum recommended dosage
  - Use lowest effective dose

IV. **CONTRAINDICATIONS**

- Do NOT administer anesthetic if:
  - Known allergy to agent
  - Unsafe dosage required
  - Patient condition increases risk beyond clinic capability

V. **MONITORING REQUIREMENTS**

- Monitor patient during and after administration
  - Observe for:
  - Allergic reaction
  - Toxicity (e.g., CNS symptoms, cardiovascular effects)
- Immediate action required if symptoms occur

VI. **ESCALATION CRITERIA**

- Immediate provider intervention required for:
  - Signs of allergic reaction
  - Respiratory distress
  - Cardiovascular instability
  - Altered mental status

VII. **AUTHORITY AND SCOPE**

- This protocol is approved by the Medical Director of NACA
- Only licensed providers administer anesthetics
- Nursing staff may assist within scope

VIII. **DOCUMENTATION REQUIREMENTS**

- Indication for anesthetic use
- Dose and type

- Patient response
- Any adverse events

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| **POLICY: MS 960** | (X) Revision (<br>) New | Original Issue Date: 11/11/24<br>Revised Date:<br>Approved by: Board of Directors<br>Approval Date: 11/20/24; 06/11/25<br>Effective Date: 12/02/24; 06/12/25<br>Annual Review Date: 06/11/25 |
| **Minimum Emergency Equipment & Supplies** | Author: Medical Staff Committee | |

**I. POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to maintain readily available emergency equipment and supplies necessary to respond to medical emergencies and protect patient safety. All clinical areas must be equipped to provide immediate response to life-threatening conditions until higher-level care is available.

**II. PURPOSE:** To establish standardized requirements for emergency equipment, supply readiness, and maintenance to ensure safe and effective response to medical emergencies.

**III. SCOPE:** Applies to all clinical areas and staff responsible for patient care and emergency response at NACA.

**IV. GOVERNANCE:** Emergency equipment standards are approved by the Medical Director and reviewed annually in accordance with MS 200 Clinical Governance. Requirements align with AAAHC standards and applicable clinical safety guidelines.

**V. STANDARDS OF CARE**

- Emergency equipment and supplies must be:
    - Readily accessible
    - Clearly organized
    - Maintained in working order
- Equipment must support management of:
    - Airway emergencies
    - Cardiac and respiratory events
    - Allergic reactions (anaphylaxis)
    - Acute deterioration
- All clinical areas must maintain minimum emergency supplies appropriate to services provided
- Staff must be trained in the use and location of all emergency equipment

**VI. MINIMUM REQUIRED EQUIPMENT AND SUPPLIES**

At a minimum, clinical areas must maintain:

- AIRWAY AND RESPIRATORY:
    - Oxygen supply and delivery devices
    - Bag-valve-mask (BVM)

- CARDIAC / MONITORING:
    - Automated External Defibrillator (AED)

    - Blood pressure equipment
    - Pulse oximeter

- EMERGENCY MEDICATIONS:
    - Epinephrine (for anaphylaxis)
    - Antihistamines (as appropriate)
    - Other emergency medications as clinically indicated

- GENERAL EMERGENCY SUPPLIES:
    - Suction equipment (if applicable)
    - Personal protective equipment (PPE)

## VII. READINESS REQUIREMENTS

- Emergency equipment must be:
    - Checked regularly (at least daily or per clinic policy)
    - Verified for completeness and functionality
- Expiration dates must be monitored
- Defective or expired items must be replaced immediately
- Equipment must remain accessible and not locked or obstructed

## VIII. DOCUMENTATION REQUIREMENTS

The following must be documented:

- Routine equipment checks (logs or EHR systems)
- Maintenance and replacement of supplies
- Staff training and competency in emergency response
- Documentation must be available for audit and review.

## IX. COMPLIANCE AND MONITORING

Compliance is monitored through:

- Routine emergency equipment checks
- Periodic audits of supply availability and condition
- Review of emergency response events
- Staff competency validation

## X. REFERENCES

- AAAHC Emergency Preparedness Standards
- CDC Emergency and Infection Control Guidance
- MS 200 Clinical Governance Policy

**MS960A EMERGENCY EQUIPMENT PROCEDURE**

1. Equipment Placement
   - Emergency equipment must be:
   - Located in designated areas
   - Clearly labeled
   - Accessible to all clinical staff

2. Routine Checks
   - Designated staff must perform regular checks
   - Daily or per established schedule
   - Verify:
     - Equipment presence
     - Functionality
     - Completeness

3. Expiration Monitoring
   - Check expiration dates of:
     - Medications
     - Supplies
     - Remove and replace expired items immediately

4. Maintenance
   - Ensure equipment is:
     - Clean
     - Operational
     - Serviced as required

5. Deficiencies
   - If issues identified:
     - Remove equipment from service if unsafe
     - Notify appropriate personnel
     - Replace or repair immediately

6. Staff Training
   - Staff must:
     - Know location of equipment
     - Be trained in use (e.g., AED, BVM)

DOCUMENTATION REQUIREMENTS
- Completion of equipment checks
- Identified deficiencies and corrective actions
- Maintenance activities
- Staff training records

COMPLIANCE AND MONITORING

- Audit of equipment check logs
- Monitoring of readiness status
- Review following emergency events

## MS960B EMERGENCY RESPONSE SUPPORT PROTOCOL

**PURPOSE**: To define expectations for the use of emergency equipment during patient emergencies.

### I. GENERAL RESPONSE

- In a medical emergency:
  - Identify emergency condition
  - Call for assistance
  - Activate emergency response (e.g., 911) as appropriate
  - Retrieve emergency equipment immediately

### II. EQUIPMENT USE TRIGGERS

- AED:
  - Cardiac arrest or unresponsive patient
- Oxygen / BVM:
  - Respiratory distress or failure
- Epinephrine:
  - Suspected anaphylaxis
- Monitoring equipment:
  - Any unstable vital signs

### III. ESCALATION

- Immediate escalation required for:
  - Cardiac arrest
  - Respiratory failure
  - Severe allergic reaction
  - Altered mental status
- Activate EMS when higher-level care is required

### IV. STAFF RESPONSIBILITIES

- All staff must:
  - Respond within scope of training
  - Use equipment appropriately
  - Assist provider during emergency
  - Providers direct clinical management

### V. DOCUMENTATION REQUIREMENTS

- Emergency event details
- Equipment used
- Interventions performed
- Patient outcome

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| **POLICY: MS 970** | ( ) Revision<br>(X) New | Original Issue Date: 04/01/26<br>Revised Date:<br>Approved by: Board of Directors<br>Approval Date: 04/15/26 Effective Date: 04/16/26<br>Annual Review Date: |
| **Medication, Medical Supply, and Medical Equipment Procurement** | Author: Medical Staff Committee | |

**I. POLICY:** It is the policy of Native Americans for Community Action, Inc. (NACA) to ensure that all medications, medical supplies, and equipment are procured, stored, and maintained in a manner that supports patient safety, regulatory compliance, and efficient clinical operations. All procurement activities must follow approved processes to ensure quality, safety, and cost-effectiveness.

**II. PURPOSE:** To establish standardized expectations for the procurement, approval, and management of medications, medical supplies, and equipment.

**III. SCOPE:** Applies to all staff involved in purchasing, receiving, storing, and managing medications, medical supplies, and equipment at NACA.

**IV. GOVERNANCE:** Procurement activities are governed by the Medical Director and organizational leadership in accordance with MS 200 Clinical Governance.

**V. APPROVAL AUTHORITY:**

- Medications and clinical supplies must be approved by the Medical Executive Committee
- Medical equipment purchases must be approved based on:
    - Clinical need
    - Safety standards
    - Budget considerations
    - New or high-risk equipment requires Medical Director approval prior to procurement

**VI. STANDARDS OF CARE**

- All medications, supplies, and equipment must:
    - Meet safety and quality standards
    - Be obtained from approved vendors
    - Be appropriate for intended clinical use
- Procurement must consider:
    - Evidence-based practice
    - Compatibility with existing systems
    - Staff competency requirements
- Medications must comply with:
    - FDA approval
    - Storage and handling requirements
- Equipment must:
    - Be maintained in safe working condition
    - Meet manufacturer specifications

- Be appropriate for outpatient clinical setting

## VII. INVENTORY MANAGEMENT

- NACA must maintain an inventory management system for:
  - Medications
  - Supplies
  - Equipment
- Inventory must be monitored for:
  - Stock levels
  - Expiration dates
  - Usage patterns
- Expired or damaged items must be:
  - Removed immediately
  - Properly disposed of according to policy

## VIII. STORAGE AND SAFETY REQUIREMENTS

- Medications and supplies must be stored:
  - According to manufacturer requirements
  - In secure and appropriate conditions (e.g., temperature control)
  - Controlled or high-risk items must be secured and access limited to authorized personnel
- Equipment must be stored and maintained to prevent damage or contamination

## IX. DOCUMENTATION REQUIREMENTS

**X.** The following must be documented:

- Procurement records (orders, approvals, receipts)
- Maintenance and service records for equipment

## XI. COMPLIANCE AND MONITORING

**XII.** Compliance is monitored through:

- Inventory audits
- Review of procurement records
- Monitoring of expiration management
- Equipment maintenance review

## XIII. REFERENCES

- AAAHC Standards for Medication and Equipment Management
- FDA Medication Safety Guidelines
- MS 200 Clinical Governance Policy

**MS970A PROCUREMENT AND INVENTORY MANAGEMENT PROCEDURE**

1. Identification of Need
   - Staff identify need for:
     - Medications
     - Medical supplies
     - Equipment
     - Requests must include:
     - Clinical purpose
     - Justification

2. Approval Process
   - Requests are presented and reviewed in Medical Executive Committee and approved based on:
     - Clinical need
     - Budget
     - Safety considerations
     - Approval must occur prior to purchase

3. Purchasing
     - Orders placed through approved vendors
     - Ensure products meet quality and safety standards

4. Receiving and Verification
   - Upon receipt:
     - Verify order accuracy
     - Inspect for damage
     - Confirm expiration dates

5. Inventory Management
   - Log items into inventory system
   - Monitor:
     - Stock levels
     - Usage
     - Expiration dates

6. Storage
   - Store items according to:
     - Manufacturer guidelines
     - Safety requirements
     - Ensure secure storage when required

7. Equipment Maintenance
   - Maintain equipment per manufacturer recommendations

- Schedule routine service and inspections

8. Removal of Expired/Damaged Items
   - Remove immediately from use
   - Document and dispose of per policy

9. Escalation
   - Escalate issues when:
     - Equipment failure occurs
     - Supply shortages impact care
     - Safety concerns are identified

DOCUMENTATION REQUIREMENTS
- Purchase approvals and records
- Inventory logs
- Equipment maintenance records
- Expired item removal documentation

COMPLIANCE AND MONITORING
- Inventory audits
- Procurement reviews
- Equipment maintenance tracking

**MS970B Clinical Item Change Request Form**

☐Medication | ☐Medical Supply | ☐Medical Equipment

**SECTION 1: REQUEST OVERVIEW**
Request Type: ☐ Add ☐ Revise ☐ Delete
Category: ☐Medication ☐ Medical Supply ☐ Medical Equipment

**SECTION 2: REQUESTOR INFORMATION**
Name: _____
Credentials: _____
Department / Service Line: _____
Date Submitted: _____

**SECTION 3: ITEM IDENTIFICATION**
Item Name (Generic / Brand): _____
Manufacturer / Vendor: _____
Current Status (if revising or deleting):
☐ On Formulary/Inventory ☐ Not Currently Available

**SECTION 4: CLINICAL JUSTIFICATION**
Intended Use / Indication:
_____
_____

Reason for Request (check all that apply):

☐Patient safety ☐ Quality improvement ☐ Guideline change ☐ Cost

☐ Replacement ☐ Low use/High Waste ☐ Avoid Urgent Care/Emergency Room

☐ Improves access, equity, or cultural appropriateness of care

**SECTION 5: MEDICATION-SPECIFIC REVIEW** (if applicable)

☐ FDA approved / authorized Controlled Substance Status: ☐ Controlled ☐ Not Controlled

☐ Dosing standards identified ☐ Storage requirements defined

☐ Requires post-implementation monitoring (e.g., usage, outcomes, adverse events)

☐Intended for emergency or backup use only

☐ High-Alert / ☐Look Alike Sound Alike / Hazardous? ☐ No ☐ Yes (describe safeguards)

**SECTION 6: SUPPLY / EQUIPMENT** REVIEW (if applicable)

☐Safety / regulatory standards met

☐Biomedical inspection required ☐Preventive maintenance required

☐Training required (attach plan if yes)

**SECTION 7: PATIENT SAFETY & RISK ASSESSMENT (Select all that apply)**

☐ Adverse clinical effects (side effects, complications, injury potential)
☐ Dosing or administration error risk
☐ Allergy or hypersensitivity risk
☐ Drug–drug or therapy interactions
☐ Risk of misuse, abuse, or diversion (if applicable)
☐ Risk of delayed recognition of adverse events
☐ Storage or handling challenges
☐ Supply chain or availability risk
☐ Device malfunction or failure risk
☐ Calibration or maintenance dependency
☐ Electrical / power supply risk
☐ Compatibility issues with existing equipment
☐ Cleaning, disinfection, or infection-control risk
☐ Physical safety risk to patients or staff
☐ Risk of cross-contamination
☐ Single-use vs reusable confusion
☐ Sterilization or disinfection requirements
☐ Biohazard or sharps exposure risk
☐ Environmental contamination risk
☐ Risk Mitigation
☐ Policy or protocol update
☐ Staff education or training
☐ Labeling or storage safeguards
☐ Monitoring and review plan
☐ Restricted use or indications
☐ Trial period / post-implementation review

**SECTION 8: OPERATIONAL IMPACT**

☐ Workflow changes ☐ Staffing impact

☐ Policy updates required Notes: _____

**SECTION 9: FINANCIAL & BILLING CONSIDERATIONS**

Estimated Initial Cost: _____

Estimated Annual Cost: _____

☐Budget reviewed ☐Purchasing thresholds acknowledged ☐Billing impact reviewed

**SECTION 10: POPULATION INTENDED (check all that apply):**

☐ Adult (18–64)
☐ Older Adult / Geriatric (65+)
☐ Pediatric (0–17)
☐ Pregnant / Perinatal
☐ Behavioral Health / Substance Use
☐ Chronic Disease Management
☐ Primary Care / Routine Use
☐ Urgent / Emergency Use
☐ Tribal / Native American Patient Population
☐ Other (specify): _____

**SECTION 11: CONTRAINDICATED OR EXCLUDED POPULATIONS**

Recommended option (check all that apply):
☐ No known population exclusions
☐ Pediatric exclusions
☐ Pregnancy / lactation contraindication
☐ Renal or hepatic impairment considerations
☐ Geriatric sensitivity
☐ Other (specify): _____

**SECTION 12: ATTACHMENTS**

☐ Clinical evidence ☐Vendor info ☐SDS ☐Cost estimate ☐ Draft policy update

**SECTION 13: MEC REVIEW**

☐ Approve
☐ Approve w/ Conditions
☐ Time-limited approval / trial period requested ( ____ days)
☐ Defer
☐ Deny All in favor: _____ All Opposed: _____

# CEO AND NACA
# PROGRAM REPORTS

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

**Key Highlights:**

- Open Drum, 6:00pm – 8:00pm, May 12th and May 26th
- Healing Center discussion, May 18, 2026
- AVAN funding discussion, May 19, 2026
- NACA Board Meeting, May 20, 2026.
- IPAC monthly meeting, May 21, 2026
- SMPR Planning Meeting, May 21, 2026
- NACA Closed for Memorial Day, May 25, 2026
- SMPR walk thru with Haley Reynolds, May 26, 2026
- HR Retention Meeting, May 27, 2026
- RCM Discission, Laura Wood, May 28, 2026
- Healing Center discussion, June 1, 2026
- SMPR Planning Meeting, June 1, 2026
- AACHC CEO site visit, Jessica Yannow, June 2, 2026
- Navajo Voters registration event, June 3, 2026
- Meet and greet BCBS tribal liaison, Kyrie Slim, June 3, 2026
- QI and Med Exec meetings, June 4, 2026
- SMPR event, June 6, 2026.
- Pharmacy Discussion, Shane Urry, June 8, 2026
- Economic Development Orientation, June 9, 2026
- Site Renovation for BH and Hopi conference, office space, June 10,2026
- Front Desk team meeting, June 10, 2026
- SMPR debriefing meeting, June 11, 2026
- AACHC Board meeting, June 12, 2026
- Stronger As One Committee meeting, June 12, 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.
- Setting up Annual Strategic Planning Mtg at Twin Arrows.

**Meeting/Events:**

- CHW Roots, June 25-26, 2026, Chandler, AZ
- Strategic Planning Meeting – Twin Arrows, July 25, 2026
- 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
      - Fully implemented.
    - Instamed
    - Waystar
  - ~ 30 visits per day per biller
    - Release of claims
      - Daily. Currently, the lag time is 6 days.
    - Collections of AR – recently on an uptick
    - 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
    - May – 250k
    - June (so far) - ~268k
      - Change in HIM – AR work back to normal
      - Need to focus on clean claims and getting to the clearing house.
      - Contracts. Laura Wood.
- 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.
- 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**
  - **Final date to be 7/31/2026**
- **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.**
  - **Stats and study done in January 2026.**
- **Revenue Generating Maximization**
  - **Overlook**
  - **Pharmacy**
  - **Xray**
  - **Phlebotomy**
  - **Mobile services**
  - **Physical Therapy**
  - **Chiropractic**
- **IDC**
  - **2024 impact from incorrect rate and incorrect billing to a Grant.**
    - **~ 500k**
  - **Provisional at 17.6%**
  - **Choose to use 15% de minimis to be conservative.**
- **Marketing**
  - **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
June 2026 Meeting-Board Report

Major Highlights

- Interviews were conducted for the Fitness Specialist and Outpatient Coder. The Billing Manager and Medical Billing Specialist were recently advertised, and interviews will be scheduled soon. The CFO was advertised and 8 applicants applied. Interviews should be scheduled upon review.
- Continuing the overview with the Relias representative on regulation management, policy pro, and incident pro in the month of May and June. The transition from HealthStream will be in January 2027 for staff training.
- The completion rate for the annual 2026 performance evaluations was 100%. which were due on May 20th. The merit pay was processed and paid on June 5, 2026. No report of any issues by supervisors or staff. The only comment by a few supervisors is to revert to the previous 5 scale rating rather than the 3 scale rating.
- Seven (7) providers form Behavioral Health were re-privileged and re-credentialed by the Med Ex Committee on June 4, 2026, as required every 2 years. One more provider will be re-privileged and re-credentialed on September 04, 2026. Four (4) providers will be due for reprivileging/re-credentialing in 2027.
- Attended several SMPR meetings for the annual run event on June 6, 2026. Successful event this year and a good number of staff worked the run event.
- The New Employee Orientation is scheduled for June 23, 2025, with 5 staff scheduled to attend.
- Dr. Chadd Nelson has finally received his AZ State Physician License and has updated his DEA certificate to NACA Health Center. The privileging and credentialing are on-going as it was at a standstill until he received the AZ License. He is ready to relocate to Flagstaff on July 7th and will report on July 13, 2026.
- The retention committee is continuing to plan for the annual staff retreat and annual open house. The committee is planning the training, activities, menu, and recognition for years of service awards. The staff is working on the plans for the annual open house on September 10, 2026.
- Three (3) 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**

| | | |
|---|---|---|
| | Finance | |
| 1 | CFO | 7/17/2026 |
| | Health Promotion | |
| 2 | Fitness Specialist | 3/31/2026 |
| | Community Development | |
| 3 | PT Overlook Ranger | 10/31/2025 |
| 4 | Overlook Ranger | 4/6/2026 |
| | Billing Department | |
| 5 | Billing Program Manager | 5/29/2026 |
| 6 | Medical Billing Specialist | 5/26/2026 |
| 7 | Outpatient Coder | New |

**Month: June 2026**
**Program: Community Development**
**Staff: Dorothy Denetsosie Gishie, Director**
**Date: June 11, 2026**

**Program Monthly Highlights:**
**Division Director: Dorothy Denetsosie Gishie**
During this reporting period, Community Development activities included staff training, program oversight, event coordination, grant development, and ongoing community engagement. I completed the required Reach UR Life (RUL) ASIST training and participated in annual program evaluations to assess outcomes, accomplishments, and areas for continued improvement.
Significant focus was placed on planning and implementation of the 43rd Annual Sacred Mountain Prayer Run, including coordination meetings to support logistics, staffing, and volunteer efforts. The event was successfully carried out with strong community participation, favorable conditions, and effective collaboration among staff and partners.
Additional support was provided for the Economic Development New Vendor Orientation, which was well attended and helped introduce new participants to program expectations and resources. The Youth Pathways Program also launched its summer programming, offering structured educational, cultural, and wellness activities for students in grades 1 through 6.
The Supportive Services Program maintained consistent outreach to unsheltered relatives through daily and weekly community engagement efforts, strengthening partnerships and ensuring access to essential resources and services. Meanwhile, the Reach UR Life Program continued advancing the Garrett Lee Smith SAMHSA grant application through budget review, narrative development, and alignment with funding priorities, supported by an external grant reviewer to strengthen the overall application process.

**Economic Development Program:**
Program Coordinator: Pearl Tsosie
Staff: OL & Grand Canyon Rangers: Jensen Lanzo, Tyrell Tsinnie, Jennifer Shelton
During May 2026, the Economic Development Program successfully conducted the monthly vendor lottery for June site assignments, with more than 150 vendors participating. Vendor occupancy remained strong, with the Grand Canyon Visitor's Center fully booked, Overlook Vista at approximately 80 percent capacity, and the Tusayan Museum at 60 percent capacity.
The program continued collaborating with the Coconino National Forest Service on site improvements, including parking lot repairs and updated signage, while road construction in Oak Creek Canyon continued to affect visitor traffic. The Grand Canyon Visitor's Center remained a highly successful vendor location, and the Tusayan Museum continued to provide sales opportunities for participating vendors.
Staff and recruitment efforts remain ongoing to support seasonal operations. Overall, the Economic Development Program continues to provide valuable economic opportunities for Native vendors through strong partnerships, effective site management, and visitor engagement.

**Reach UR Life (RUL) Program:**
Program Manager: Onelia Soto:
Staff: Shoshana James, Angelina Tso, Anya Ashley
During the reporting period, the Reach UR Life (RUL) program continued life skills training at the Coconino County Juvenile Detention facility and completed one intake referral with a scheduled follow-up appointment.
Team coordination remained active through daily check-ins, weekly collaboration meetings, and monthly partner meetings, with increased frequency and duration to support grant preparation and ongoing program planning.
The program continued pursuing multiple funding opportunities, including submitted applications to the Arizona Community Foundation Flagstaff and the Tony Robbins Foundation, with additional applications pending or in progress, including the Health First Foundation Northern Arizona and the Garrett Lee Smith (GLS) SAMHSA grant due June 15, 2026.

Community engagement activities included hosting Phoenix Indian Center focus groups, participating in the De-Stress Fest presentation at Coconino High School, and continuing bi-weekly Mental Health Break sessions to support wellness and prevention efforts.

**Pathways Program:**
Program Coordinator: Kateri Slim
Staff: Joi Lynch: Recreational Assistant
The Pathways Program successfully concluded the school year with a positive end-of-year gathering that included reflection activities, creative student projects, and a community celebration. Students participated in cultural and appreciation-based activities earlier in the month and were recognized for their efforts with a shared meal and wellness-focused gifts.
Staff shifted focus toward planning the upcoming Pathways Summer Series, which will provide structured weekly programming centered on youth engagement, life skills, and cultural enrichment. Program leadership also contributed to the successful coordination of NACA's 46th Annual Sacred Mountain Prayer Run, which was well attended and supported strong community participation.
Overall, Pathways maintained high levels of youth engagement throughout the period, with continued service delivery and collaboration across partner programs to support youth development and wellness.

**Supportive Services Program:**
Supportive Services Case Manager: Selena Holgate
Supportive Services maintained consistent community outreach during the reporting period through ongoing engagement with key partners, including Flagstaff Family Food Center, Flagstaff Shelter Services, Crowns Traditional House, Taylor House, Mountain Line, and the Inter-Tribal Council of Arizona. Regular outreach and on-site visits supported unsheltered relatives and individuals seeking services through follow-ups, resource navigation, and distribution of basic needs such as hygiene kits, PPE, clothing, and transportation assistance, while continued participation in coordination meetings strengthened collaboration and referral processes across programs.
Direct client assistance continued through Program 1980, providing support with rental, utility, education, burial, and transportation needs, along with distribution of bus passes, Better Bucks, food and gas cards, and essential supplies. Program 7014 maintained health and safety resources, while partnerships with Mountain Line and Taylor House continued to support transportation and lodging assistance efforts.
Overall, the program sustained strong community presence, expanded collaboration efforts, and continued delivering essential resources to support stability and basic needs for community members.

**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**
**May 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:**

- **May 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, 194 regular day bus passes and assisted with one food & gas card. Distributed 158 better bucks for February 2026. Distributed ninety 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 May 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. The backpack will be delivered in July 2026.

- **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 5/6/26, 5/13/2026, 5/14/2026, 5/19/2026, 5/21/26 and 5/28/2026. 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 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 warm". 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**
**May 2026**

**Community Events:**

The Community Event for the past month May 2026 was the monthly lottery, which was held on Sunday, May 3, 2026, for the month of June, 2026. The Overlook Vista, Grand Canyon Visitor's Center, and Tusayan Museum were on the lottery list of sites to sell. 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, making sure everything balanced. That is another logistics matter all in its own, but we managed to get it done for the month of April.

The monthly lottery June 2026. The Grand Canyon Visitor's Center sold out, as usual, and with the Overlook not too far behind at 80%. The Tusayan Museum at about 60% 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. Road construction is still happening down Oak Creek and it's hindering the visitors that usually come and go all day long. I have been getting quotes for the GT work that needs to be done.
- **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 has slowed in business, but visitors are still coming into the area and visiting with the vendors that are there selling their goods.

**Economic Development Program**

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.
The Overlook positions are still open and now advertise the positions with the Nava-Hopi Times.
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 - June 2026**

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

    1. **Training that has been scheduled** -
        - Life skills
            - Coconino County Juvenile Detention – 06/02,6/09,6/18,6/25

2. **Intakes - Angie** – Received one referral and has scheduled an intake appointment.

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. RUL meetings have been more frequent and longer in duration this past month due to grant application preparation.

4. **Grant opportunities for RUL -**
    - Health First Foundation Northern Arizona – Grant application is pending. We will be notified of the award determination by the end of June.
    - RUL submitted the application for the Arizona Community Foundation Flagstaff on April 22, 2026. We have not yet been notified of the award.
    - Tony Robbins Foundation – Application was submitted 03/06/26. We have not received any status notification (approved or denied).
    - Garret Lee Smith (GLS) Grant – SAMHSA – Reach UR Life is in the process of completing an application. The application is due June 15, 2026.

5. **Update With Partners/Community**
    - RUL is provided space for Phoenix Indian Center focus groups on May 16, 2026, from 8:30 am to 1:30 PM
    - RUL participated in De-Stress Fest presentation at Coconino High School on Thursday, May 14, 2026
    - RUL has resumed Mental Health Breaks every two weeks.

**Month: May-June**
**Program: Pathways Youth Program**
**Staff: Kateri Slim, Joi Lynch**
**Date: June 10, 2026**

**Program Highlights**

- **May's highlight for Pathways was our End-of-the-Year Gathering. Both groups of participants came together for an afternoon filled with fun activities, reflection, and celebration. Students participated in an end-of-the-year reflection activity, enjoyed a meal from Raising Cane's, and were joined by several parents for the event. To encourage a healthy and hydrated summer, each student received a personalized water bottle as a gift.**

- **Earlier in the month, students created personalized canvas bags as Mother's Day gifts. They also made handmade cards filled with thoughtful and heartfelt messages for their mothers. These activities provided students with an opportunity to express their creativity and appreciation while ending the school year on a positive note.**

- **As the school year came to a close, Pathways staff spent the remainder of May preparing for the upcoming Pathways Summer Series. This four-week program, held throughout June and July, features themed weeks filled with engaging summer activities, healthy life-skills education, and cultural enrichment opportunities.**

- **During this same time, Kateri, Pathways Coordinator, took on the lead role in organizing NACA's 46th Annual Sacred Mountain Prayer Run (SMPR). While coordinating the event was a significant undertaking, the race was a great success. Community members came together to enjoy the morning, celebrate their culture, and promote health and wellness. The event ran smoothly and served as a meaningful reflection of community strength and unity.**

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**Program Lows**

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

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**Client Engagement & Attendance**

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

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**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.**

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**Network Meetings & Collaboration**

- **SMPR Meeting – May 28 - June 1, 3**
- **NACA Leadership Meeting – May 7**
- **Grant Committee Meeting – May 26**
- **One-on-one meeting with Dorothy Gishie, Community Development Director – May 6**

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**Program Trainings**

- **There were no trainings during this month period**

# May 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 report booklet

Grant committee meeting

Communityshares planning

MMIW event planning

MMIW Proclamation

Bluebolt campus advertising

Open house planning

Staff retreat survey

NACA merch from MadMonkey

NACA merch from 4imprint

Climate resilience workshop flyer

Cinco de mayo salsa contest

Staff headshots

NACA at walk for wellness

Emailing Lily Gladstone

KUYI Koffee Talk

Issues with Mailchimp

HeyFamm business listing boost

Native nonprofit day

NACA logo package

Memorial Day closure

Staff BBQ potluck

Navajo Nation Voter Registration Event

Annual performance reviews

CIP Day at the park

Flagstaff pro rodeo

HIPAA certification renewal

Wellness conferences

## Department Tasks:

### Family Health Center –

brochures

PCMH infographic on website

### Behavioral Health –

Business cards for providers

Provider bios

### Health Promotions -

Cooking class

What can I eat class

Newsletter and Calendar

Gardening event

Spring into summer hiking series

# May 2026 Marketing Report

Front Desk coverage

Pathways – Thunderbird Supply Company donation

Community Development –

Economic Development – Updated postcards

Updated brochure

Vendor bio fillable form

Facebook events

Supportive Services –

RUL – ASIST

website page revision

recreating registration form on surveymonkey

marketing meetings

QPR training

Ongoing Tasks:

KTNN & KUYI Radio advertising campaign

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

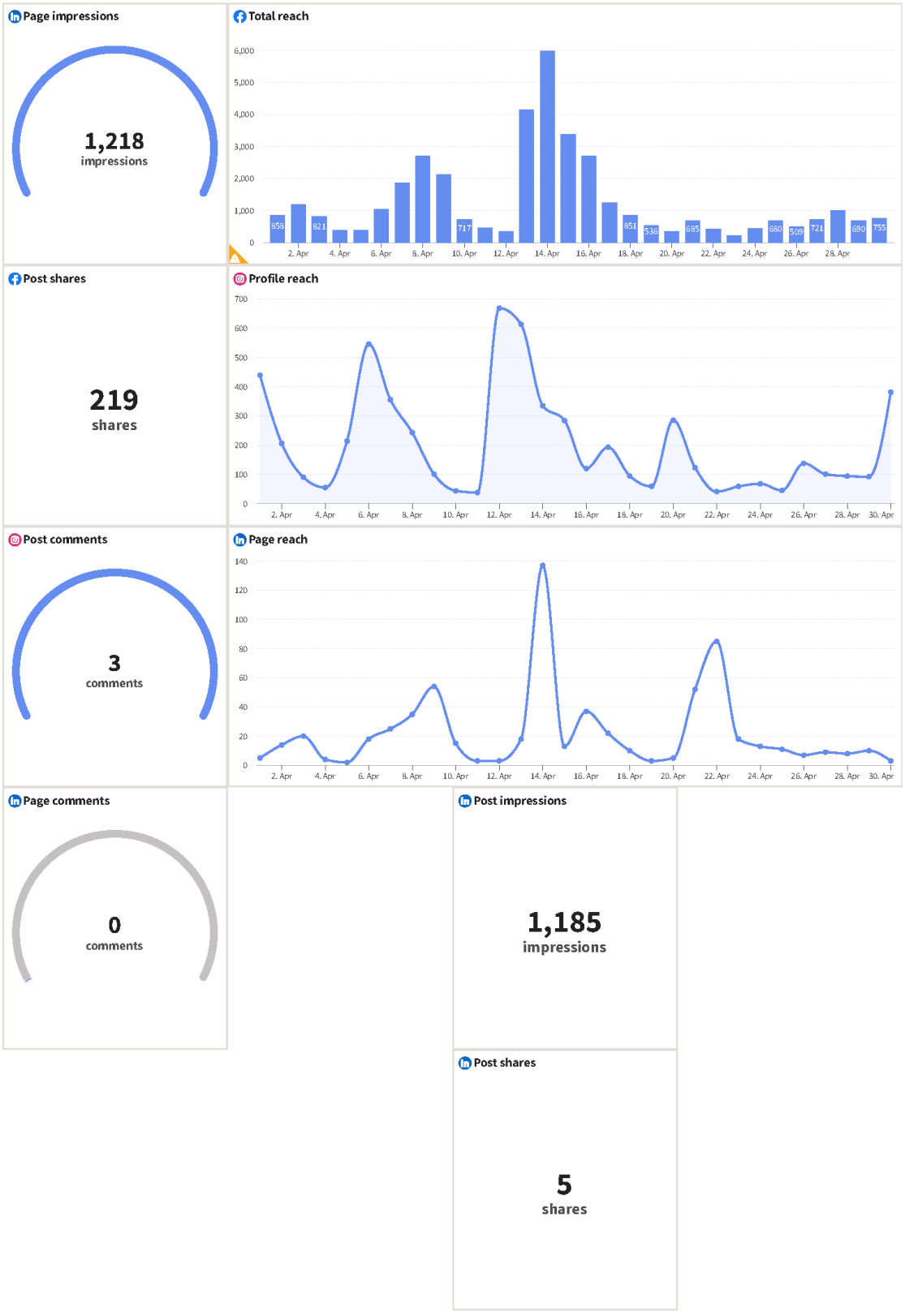
Strategic Planning Committee

…..and more!

Use the Linktree below to find NACA on Social Media:

https://linktr.ee/NACAFlagstaff

# May 2026 Marketing Report



NACA
NATIVE AMERICANS FOR COMMUNITY ACTION

# NACA Quality Improvement & Compliance

Board of Directors Report | June 2026

*Francisco Rendon, QI & Compliance Director*

## Section 1: Highlights & Challenges

### Major Highlights

- **Policy Restructuring:** NACA has restructured its Medical Services policies into a three-component framework — Policy (Board-approved direction), Procedure, and Protocol — so the Board approves only organizational direction while operational and clinical detail is maintained by appropriate leadership. This focuses Board authority, reduces unnecessary review burden, and positions NACA for the anticipated AAAHC 2027 standards (see Section 2).
- **Site Management Initiative Launched:** A custodial role-clarity and accountability initiative is underway, building a laminated daily custodial checklist and clearer task ownership across departments — directly responsive to housekeeping and infection-control findings from hazard rounds (see Section 8).
- **Relias Platform Launch:** NACA is implementing Relias as a centralized platform for competency evaluation, policy management, and incident tracking, with full implementation targeted for October 2026. Once live, it will replace the current Excel-based incident tracking and give NACA auditable, organization-wide systems for staff competency, policy access, and incident reporting (see Section 5).

### Major Challenges

- **Cyber/Ransomware Readiness Gaps:** A response plan is in development ahead of anticipated V45 accreditation standards, which are expected to weigh heavily on cybersecurity and AI governance (see Section 5).
- **IHS Final Report Still Pending:** The final IHS report from the February 20 site visit has not yet been received, and the Exit Meeting remains to be rescheduled (see Section 2).
- **Open Patient Complaints Under Review:** Two informal patient complaints opened late in the period remain under active review as of June 11 — a Behavioral Health provider-assignment complaint and an ACO/data-sharing concern tied to an external payer letter (see Section 3).
- **Key Finance Vacancies:** Critical Finance positions — most notably the CFO and billing/coding roles — remain unfilled and are a top organizational priority. CFO recruitment is showing positive movement, with applications now being received, but the continued billing/coding gaps carry direct revenue-cycle and compliance implications. Filling these roles remains essential to financial stability and sustained compliance performance.

## Section 2: Compliance & Risk Management

### Accreditation & Regulatory

- **IHS Site Visit:** Completed February 20, 2026. The final IHS report has not yet been received, and the Exit Meeting remains to be rescheduled. No further movement this period.
- **AAAHC:** NACA is ACCREDITED. Accreditation period: December 9, 2025 – December 9, 2027.
- **ADHS:** Application is up to date. No further updates at this time.
- **WCAG Accessibility (Regulatory):** Web accessibility compliance work is active. A corrective timeline is in progress with a July 8 milestone and a working session scheduled for mid-July; the QI/C Director is coordinating, with review work delegated across web/mobile, diagnostic equipment, and clinical areas.

### Risk Management — Staffing & Hiring

- Finance department recruitment is showing positive movement — CFO applications are now being received.
- Several critical Finance and Billing/Coding positions remain a priority to fill.

## Annual Policy Reviews

- **Approved May 20, 2026:** The Board reviewed and approved the Infection Control (IC) and Laboratory Services (LS) policies and procedures.
- **Due June 17, 2026:** Medical Services (MS) review will be presented at the June Board meeting.
- **Policy Standardization & Restructure:** Policies are being restructured into a three-document format (policy / procedure / protocol) with governance and scope statements, in preparation for AAAHC accreditation. As part of this standardization, the QI/C Director now presents all board-facing policies for consistency.

## Policy Management Improvement Initiative — Medical Services (FY 2025–2026)

- **Background:** During FY 2025–2026, the Medical Services Department completed a comprehensive review and restructuring of the organization's clinical policies and procedures in preparation for AAAHC re-accreditation. The previous format combined policy, procedure, and clinical protocol into a single document, creating several governance challenges:
- The Board was required to approve operational and clinical procedure details that change frequently as practice standards evolve.
- Policy ownership, governance responsibility, and organizational authority were not clearly defined within each document.
- **Quality Improvement Action:** To address these gaps and align with emerging AAAHC standards — including updates anticipated with the 2027 publication — NACA adopted a three-component policy framework across all Medical Services policies, summarized below. All policies were also reformatted into standardized sections: Policy Statement, Purpose, Scope, Governance, Guidelines, and References.

| Component | Definition & Approval Authority |
|---|---|
| **Policy** | Board-approved organizational direction, values, and expectations. This is the component presented to and approved by the Board of Directors. |
| **Procedure** | Operational processes describing how staff implement the policy. Maintained by the responsible leader for the policy's domain — for example, the CEO, DOO, QI & Compliance Director, or HR Director for administrative policies, and the Medical or Behavioral Health Director for clinical policies; not subject to Board approval. |
| **Protocol** | Clinical decision-making guidance and standing orders, where applicable. Authorized by the responsible clinical authority — the Medical Director for medical services and the Behavioral Health Director for behavioral health — and maintained by the appropriate clinical committee; not subject to Board approval. |

- **Governance Clarification:** Under the revised framework, the following structure applies:
- **Board of Directors —** Approves the Policy component of each document, representing the organization's stated direction and values.
- **MEC / Medical Staff Committee —** Authorizes clinical procedures and protocols; the Medical Director reviews and approves clinical protocol content (the Behavioral Health Director serves the equivalent role for behavioral health).
- **QI & Compliance Committee —** Monitors compliance with adopted policies and reviews significant procedure or protocol changes.
- **Leadership Team —** Responsible for implementing and maintaining operational procedures within their respective departments.
- **Rationale for Change:** The revised format focuses the Board's review and approval authority on organizational policy direction, while allowing procedures and clinical protocols to be maintained by

appropriate clinical and administrative leadership as standards evolve. This reduces unnecessary Board burden, improves document management, and positions NACA to meet anticipated AAAHC 2027 standards updates, which reflect a broader movement toward governance-focused policy frameworks in ambulatory accreditation.

- **Current Status:** All Medical Services policies have been reformatted into the new three-component structure and are being transitioned into Relias (Policy Pro module) for centralized document management and organization-wide staff accessibility. The revised policies are presented to the Board for approval at the June 2026 meeting. Two new policies are included: MS 680 (Routine Depression Screening, Patients Aged 8 and Older, originally approved February 2025) and MS 970 (Medication, Medical Supply, and Medical Equipment Procurement, approved April 2026). Seven previously standalone policy numbers have been consolidated into related policies with no substantive content loss; a complete Summary of Changes is provided as an attachment. Clinical leadership and the Medical Director have reviewed all policies containing substantive clinical or operational content prior to this submission.

### Change Summary by Category

| Change Category | Count | Board Impact | Description |
|---|---|---|---|
| Formatting / Governance Revision | 18 | Low | Standardized format; no substantive change to policy direction. |
| Operational Clarification | 5 | Low | Workflow clarifications; no major policy intent change. |
| Operational / Clinical Clarification | 8 | Moderate | Reviewed by clinical leadership prior to Board submission. |
| Clinical Revision | 2 | Moderate | MS 310 (Hypertension) and MS 320 (Diabetes) — substantive protocol updates reviewed by Medical Director. |
| Structural Consolidation | 7 | Low | Seven standalone policy numbers consolidated; no content lost. |
| New Policies | 2 | Moderate | MS 680 (Depression Screening, Feb 2025) and MS 970 (Procurement, Apr 2026). |
| **Total Policies / Numbers Reviewed** | **42** | | |

## Section 3: Incident Report Summary

*Reporting period: May 14 – June 11, 2026*

*Note: This period picks up the day after the prior board reporting window (April 8 – May 13) closed. Incident volume dropped sharply, from 16 in the prior period to 3.*

| 3 | 0 | 0 | 2 |
|---|---|---|---|
| Total Incidents (May 14 – Jun 11) | Staff Injuries | HIPAA / PHI Breaches | Open Complaints — under review |

### Incident Category Breakdown

| Incident Category | Count | Department |
|---|---|---|
| Patient Complaint (Informal) | 2 | BH / FHC |

| Incident Category | Count | Department |
|---|---|---|
| Employee / Community Complaint | 1 | Admin |
| **TOTAL** | **3** | |

### Key Themes

**A Markedly Quieter Period.** After a heavy prior cycle concentrated in FHC, this period saw only three reports, none involving patient safety events, medication errors, staff injuries, HIPAA breaches, or vaccine adverse events. The three reports were complaint-driven rather than clinical, and are spread across three different departments rather than concentrated in one.

### Patient Safety Indicators

| Indicator | This Period (May 14–Jun 11) | Prior Period (Apr 8–May 13) |
|---|---|---|
| Medication errors | 0 | 0 |
| Patient injuries at facility | 0 | 0 |
| Vaccine adverse events | 0 | 1 |
| Mandated reports filed (DCS / FPD) | 0 | 1 |
| HIPAA / PHI incidents | 0 | 1 |
| Staff injuries | 0 | 2 |
| Patient complaints received | 2 | 1 |
| Patient complaints closed this period | 0 | 1 |
| Employee complaints | 1 | 2 |

## Section 4: GPRA Performance Report

**Reporting Period:** October 1, 2025 – June 8, 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:** 70.59% — well above the 57% target and up 4.4 points from prior year; the strongest diabetic measure this period.
- **Depression Screening Ages 12–17:** 47.95% — above the 36% target.
- **Controlling High Blood Pressure (Million Hearts):** 48.25% — at the 48% target, up 13.8 points year-over-year.
- **Statin Therapy — CVD Prevention:** 37.59% — crossed above the 36% target (up 4.0 points), a new gain this period.
- **Adult Immunizations — Pneumococcal Vaccine:** 41.38% — above the 39% target.

### Notable Improvement Trends (Year-over-Year)

- **Diabetic Retinopathy:** 44.12%, up 15.7 points from prior year — within 3 points of the 47% target. Strong, sustained movement; IHS coding requirements remain under review.
- **Diabetes: Nephropathy Assessment:** 42.65%, up 15.6 points — now within 1.4 points of the 44% target.

- **Cardiovascular control:** Diabetes Blood Pressure Control and Controlling High Blood Pressure both posted large year-over-year gains, reflecting the chronic-disease focus under PIP #1 and the diabetes/hypertension protocol overhaul.

## Areas Requiring Focused Attention

- **SBIRT:** 0% — stagnant.
- **HIV Screening:** 2.94% against a 42% target. A workflow and standing-orders conversation is needed.
- **IPV/DV Exam:** 11.61% against a 30% target. Workflow development continues.
- **Cancer Screenings (Mammogram, Cervical, Colorectal):** All remain well below IHS targets, with mammography down year-over-year.
- **Tobacco Use Assessment (Screening + Use):** Both measures declined from prior year and sit well below the 50% target — workflow evaluation ongoing.
- **Depression Screening Age 18+:** 32.13%, down 15.3 points from prior year and now below the 39% target — continued outreach recommended.

## Full GPRA Performance Table — October 1, 2025 to June 8, 2026

*Green shading indicates the measure is at or above the IHS target. Diabetes Glycemic Control is an inverse measure (A1c <9 uncontrolled); for that measure, lower is better and the target is a ceiling.*

| Measure | IHS Tgt | Prior Yr | Current Yr | Trend / Notes |
|---|---|---|---|---|
| Access to Dental Services | 27.0% | 0.08% | 0% | No change — staffing gap |
| Adult Immunizations — Pneumococcal Vaccine | 39.0% | 45.59% | **41.38%** | Above target; down YOY |
| Adult Immunizations — Shingrix | 39.0% | 30.68% | 32.81% | Improving; below target |
| Adult Immunizations — TDaP | 39.0% | 29.08% | 27.82% | Slight decline |
| Adult Immunizations Comprehensive | 39.0% | 25.02% | 24.01% | Slight decline |
| Adult Immunizations TDaP/Td | 39.0% | 25.11% | 23.93% | Slight decline |
| Adult Influenza Immunization | 21.0% | 11.65% | 6.69% | Season-dependent; expected |
| Alcohol Screening | 36.0% | 45.82% | 35.36% | Just below target; down YOY |
| Cancer Screening: Mammogram Rates | 40.0% | 33.66% | 26.96% | Persistent gap; down YOY |
| Cervical Cancer Screening | 35.0% | 14.93% | 14.12% | Persistent gap |
| Child Influenza Immunization | 18.0% | 13.00% | 8.79% | Season-dependent; expected |
| Childhood Weight Control | 22.0% | 100% | **100%** | Sustained — well above target |
| Colorectal Cancer Screening | 24.0% | 9.27% | 9.66% | Marginal; below target |
| Controlling High Blood Pressure (Million Hearts) | 48.0% | 34.48% | **48.25%** | At target; strong YOY gain |
| Dental Sealants | 11.0% | 1.52% | 0% | No change — staffing gap |
| Depression Screening: Age 18+ | 39.0% | 47.45% | 32.13% | Below target; down YOY |
| Depression Screening: Ages 12–17 | 36.0% | 57.69% | **47.95%** | Above target |

| Measure | IHS Tgt | Prior Yr | Current Yr | Trend / Notes |
|---|---|---|---|---|
| Diabetes Glycemic Control (A1c <9 — inverse) | 12.0% | 33.78% | 32.35% | Inverse — higher = more uncontrolled |
| Diabetes: Blood Pressure Control | 57.0% | 66.22% | **70.59%** | Above target — up YOY |
| Diabetes: Nephropathy Assessment | 44.0% | 27.03% | 42.65% | +15.6 pts; approaching target |
| Diabetic Retinopathy | 47.0% | 28.38% | 44.12% | +15.7 pts; near target |
| HIV Screening | 42.0% | 3.00% | 2.94% | Persistent gap — workflow needed |
| Intimate Partner & DV (IPV/DV) Exam | 30.0% | 12.05% | 11.61% | Below target; workflow in progress |
| SBIRT | 15.0% | 0% | 0% | No movement — QI action needed |
| Statin Therapy — CVD Prevention | 36.0% | 33.64% | **37.59%** | Crossed above target |
| Statin Therapy — CVD Risk/Diabetes | 52.0% | 100% | **100%** | Sustained — well above target |
| Tobacco Cessation | 27.0% | 14.71% | 14.11% | Persistent gap — flat |
| Tobacco Use Assessment: Screening | 50.0% | 45.17% | 32.44% | Below target; down YOY |
| Tobacco Use Assessment: Tobacco Use | 50.0% | 41.24% | 28.02% | Below target; down YOY |
| 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%):** 32.35% — elevated (above the ceiling; lower is better). Remains the active focus under PIP #1 and the Glycemic Control Subcommittee. The diabetes/hypertension protocol overhaul (GLP-1s first-line, updated BP thresholds) is now in place to support this work.
- **No-Show Reduction PIP:** Ongoing in collaboration with the DOO. LUMA (live May 12) remains the primary action item; PDSA data analysis is being developed with the support from HIM/HISS.
- **Retinopathy Exam Completion (goal 47%):** 44.12% — approaching target, up sharply year-over-year.
- **Diabetes: Blood Pressure Control (goal 57%):** 70.59% — well above target and improving.
- **Controlling High Blood Pressure (Million Hearts, goal 48%):** 48.25% — now at the IHS target; monitoring continues.
- **Statin Therapy — CVD Prevention (goal 36%):** 37.59% — crossed above target this period.
- **Annual/Wellness Exam, rolling 12 months (goal 50%):** No change / data pending — measure not included in the current GPRA pull; follow-up to confirm tracking source.
- **Hand Hygiene (goal 85%+):** Monitoring ongoing; QUEST audit confirmation in progress.

### HIM & Technology Updates

- **LUMA:** Live since May 12. There are implementation issues but they are being addressed.
- **NextGen 8 (NG8) Upgrade:** Scheduling follow-up is underway with the vendor; NACA is awaiting a confirmed upgrade date.

- **Population Health:** Data-validation work continues to hold NextGen accountable for clean reporting, addressing industry-wide data-quality concerns. GPRA reporting resets October 1.
- **Cybersecurity Readiness (V45 Prep):** A ransomware response plan is in development following a tabletop exercise that surfaced significant. Work includes referencing NextGen's existing cyber protocols rather than building from scratch. The forthcoming V45 accreditation standards are anticipated to weigh heavily on cybersecurity.
- **AI Governance:** NACA is developing its organizational stance on AI use (current use limited to ambient documentation, with updated consent and opt-out). This work ties to Urban Indian Organization data-sovereignty considerations.
- **Relias Implementation:** Rollout is in progress across three tracks, with a full implementation target of October. Incident Pro will eventually replace the current Excel-based incident tracking.

### Performance Improvement Projects (PIPs) 2025–2026

| PIP | Quality Activities |
|---|---|
| **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:** June 25, 2026

## Section 6: Patient Satisfaction

*Note: NACA's board reporting runs mid-month rather than calendar-month, and survey collection windows vary in length. As a result, the per-period respondent count is small and will fluctuate; results should be read as directional rather than statistically robust, and are best interpreted against the 2025 baseline and longer-term trend.*

Patient satisfaction data was collected via voluntary electronic and paper survey across NACA service sites for the current reporting period (n=7). This cohort was Family Health Center–weighted (5 of 7 responses from FHC; 2 without a recorded site). Behavioral Health and the Wellness Center had no submissions in this cohort.

| 4.83 | 50% | 4.66 | +0.17 |
|---|---|---|---|
| Current Overall Avg (n=7) | Referral Favorable (3 of 6) | 2025 Baseline Avg (n=26) | vs. 2025 Baseline |

### Overall Satisfaction Trend

Current-period overall satisfaction averaged 4.83 out of 5.00, holding above the 2025 baseline of 4.66 and consistent with the strong results of recent months. Access and logistics domains remained excellent, while clinical-interaction domains softened — a pattern tied to the small, FHC-heavy respondent mix rather than a clinical-quality concern at this sample size. Referral likelihood was favorable for 3 of 6 responding (one strongly negative outlier drove the rate down); given the otherwise high domain scores, this does not indicate a systemic trust issue but will be monitored.

## Domain Score Comparison — Current Period vs. Baseline

| Domain | 2025 Baseline | Current Period | Trend vs Baseline |
|---|---|---|---|
| Ease of Getting Care / Access | 4.69 | 5.00 | ▲ +0.31 |
| Hours This Location Is Open | 4.54 | 5.00 | ▲ +0.46 |
| Prompt Return on Calls | 4.46 | 5.00 | ▲ +0.54 |
| Time in Waiting Room | 4.50 | 5.00 | ▲ +0.50 |
| Time in Exam Room | 4.35 | 4.57 | ▲ +0.22 |
| Waiting for Tests | 4.31 | 4.86 | ▲ +0.55 |
| Listens to You | 4.85 | 4.43 | ▼ -0.42 |
| Takes Enough Time with You | 4.69 | 4.43 | ▼ -0.26 |
| Explains What You Want to Know | 4.85 | 4.43 | ▼ -0.42 |
| Gives Good Advice and Treatment | 4.88 | 4.43 | ▼ -0.45 |
| Input into Care Decisions (Provider) | 4.81 | 5.00 | ▲ +0.19 |
| Friendly and Answers Qs (Provider) | 4.81 | 5.00 | ▲ +0.19 |
| Input into Care Decisions (Staff) | 4.81 | 5.00 | ▲ +0.19 |
| Friendly and Answers Qs (Staff) | 4.85 | 4.71 | ▼ -0.14 |
| Cost / Billing Fairness | 4.27 | 4.67 | ▲ +0.40 |
| Neat and Clean Building | 4.73 | 5.00 | ▲ +0.27 |
| Ease of Finding Where to Go | 4.69 | 5.00 | ▲ +0.31 |
| Comfort and Safety While Waiting | 4.73 | 5.00 | ▲ +0.27 |
| Privacy and Confidentiality | 4.69 | 5.00 | ▲ +0.31 |
| Culture and Traditions Respected | 4.65 | 5.00 | ▲ +0.35 |
| **OVERALL AVERAGE** | **4.66** | **4.83** | **▲ +0.17** |

## Key Insights — Current Period

### 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.
- Staff and provider engagement domains — Input into Care Decisions, Friendly and Answers Questions (provider and staff), Neat and Clean Building, Ease of Finding Where to Go, Comfort and Safety, Privacy, and Culture and Traditions — all scored 5.00 or near it.
- Cost / Billing Fairness held at 4.67 — well above the long-standing 4.27 baseline, consistent with recent months' billing improvement.

### Areas to Monitor

- Clinical-interaction domains — Listens to You, Takes Enough Time, Explains What You Want to Know, and Gives Good Advice — all scored 4.43, down from baseline. At n=7 with an FHC-heavy mix, this reflects sample composition rather than a clinical-quality signal, but warrants tracking.
- Referral likelihood (3 of 6 favorable) was pulled down by a single strongly negative respondent; monitored.
- Patient comments again flagged provider turnover and front-desk responsiveness, and multiple respondents requested Saturday hours (9–2). These themes are consistent with prior months and relevant to PIP #2 and #5.

### Health Literacy — Current Period

| Literacy Measure | Current | Read |
|---|---|---|
| Understands Medical Home Concept | 43% | Low — provide more patient education |
| Emergency Care Awareness | 100% | Strong — continue current approach |
| Urgent Care Awareness | 100% | Strong — continue current approach |
| Knows How to Get Medical Records | 100% | Strong — continue current approach |
| Knows Provider Availability | 100% | Strong — continue current approach |

Patients are consistently clear on where to get emergency and urgent care, how to access their records, and provider availability — all at 100%. The one measure to act on is understanding of the medical home concept (43%), where roughly half of respondents are unsure what a medical home is. Recommended response: reinforce medical-home language in patient-facing touchpoints — appointment reminders (now supported by LUMA) and front-desk interactions. This remains a standing recommendation from prior cycles.

## Section 7: Peer Review

Review cycle: May 2026 | Forms collected: 12 (4 staff × 3 reviewers) | Max score: 18 pts | Rating: Exceeds=3 | Meets=2 | Improvement Needed=0

### Domain Ratings & Scores

| Staff Member | Clinical Competence | Communication | Professionalism | Teamwork | Cultural Competency | PCMH | Avg Score |
|---|---|---|---|---|---|---|---|
| **Dr. Arhin** | Meets | Meets | Exceeds* | Exceeds | Meets | Meets | ~70% |
| **Taylor Wahl-Fabrega** | Exceeds | Exceeds | Exceeds | Exceeds | Exceeds | Meets/Exc | ~96% |
| **Ruth DeBoard** | Meets | Meets/Exc | Meets/Exc | Meets | Meets | Meets | ~69% |
| **Sylvia Smith** | Meets | Meets | Meets/Exc | Meets | Meets | Meets | ~69% |

**Dr. Arhin received Exceeds in Professionalism from one reviewer. Rating key: Exceeds=3 | Meets=2 | Improvement Needed=0. Max score: 18 pts (4 staff × 3 reviewers = 12 forms).*

**Peer Comments: Dr. Arhin —** Strong patient rapport; actively shares knowledge in meetings. **Taylor Wahl-Fabrega —** Top performer this cycle; 18/18 on one review; warm and professional. **Ruth DeBoard —** Knowledgeable and courteous; **Sylvia Smith —** Willing and effective.

## Section 8: Emergency Management & Safety

### Safety Plan & Facility Overview

- **Safety Plan:** Reviewed and approved by the Board of Directors. No changes this period.
- **Facility Fire Inspection:** Fire extinguishers were current with updated tags at all five sites during May rounds. Annual inspection due date: July 8, 2026.

## Facility Drills

- **Completed Drills (2026):** NACA conducts four emergency drills per year.
  - **Q1 — Snow Delay (January 9, 2026): Real event, documented as an operational drill.** Complete.
  - **Q2 — Measles Drill (June 15, 2026):** Scheduled; falls after the June board cutoff, so results report in July.
- **Drill Cadence:** The Q1 drill is complete and the Q2 drill is scheduled for June 15, keeping NACA on track for full-year compliance.
- **Emergency App:** Not utilized in the past month.

## Monthly Hazard Surveillance Rounds — May 28, 2026

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. Most clinical areas were organized and in good order. May rounds incorporated findings from the Infection Control audit, adding 15 new items to the follow-up tracking log, each assigned to a responsible party.

| Total Findings (Open) | Deficiencies (Open) | Near Compliance (Open) | Closed This Period |
|---|---|---|---|
| 51 open items | 17 open | 34 open | 3 closed |

### Notable Findings This Period

- **Infection Control — Handwashing Supplies:** Missing soap identified at two handwashing stations (FHC lab and the medication/vaccine room). Restock required, with handwashing-station checks to be added to daily rounds.
- **Infection Control — Expired/Misdated Supplies:** Expired or misdated items found across multiple FHC areas (gloves in lab, needles in the vaccine room, glucose strips and control solution in the retinopathy room, goggles in Exam 6 & 7, and a misdated speculum box). Nursing staff to complete a sweep and log corrections.
- **Electrical Panel Access (GSA/Admin):** Back-room electrical panel cannot be opened — key is missing. Panel must remain accessible per life-safety standards; locating access is a priority.
- **Eyewash Station (FHC):** Sticker ripped; station expires September 2026. Replacement and expiration monitoring needed; to be confirmed on the monthly inspection log.
- **TRX A-Frame (Wellness Center):** Remains unbolted per IHS safety recommendation; contractor action pending.

## Next Steps — Facilities & Safety

- Fire extinguisher annual inspection due: July 8, 2026.
- Exit sign annual inspection to be scheduled before July 2026.
- Eyewash station expiration to be monitored — renewal due September 2026.
- Follow up with Facilities on ADA restroom corrections across FHC and GSA.
- Locate electrical-panel access key (GSA/Admin).
- IC-audit supply findings (soap, expired items) to be cleared and added to daily checklist routines — ties to the Site Management custodial-checklist initiative (Section 1).

## 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: June 25, 2026.
- **Emergency Management & Safety:** Ongoing.
- **Medical Executive Committee (MEC):** Ongoing — active on peer review this cycle (Section 7).
- **Directors / Leadership:** Ongoing.
- **Infection Control Committee:** Ongoing — IC audit completed this period (Section 8).
- **All-Clinic Staff Meetings:** Ongoing.
- **AAAHC Workgroup:** On hold.
- **Glycemic Control Subcommittee:** Active — see Section 10.

## Section 10: Glycemic Control Subcommittee Update

*No Glycemic Control Subcommittee meeting was held during this reporting period. The following reflects the most recent subcommittee status. Next subcommittee meeting: June 18, 2026.*

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.

## Section 11: Next Gen Tribal Health Conference Highlights

**Patient Engagement & No-Show Reduction** The Feather River tribal health organization presented documented outcomes from their LUMA patient engagement implementation: 10,000 additional appointments scheduled annually and a 1.5% reduction in their no-show rate. They also reported significant improvement in GPRA scores after gaining real population visibility through POP Health. These figures are directly relevant to NACA's active no-show PIP and serve as a benchmark for what targeted patient engagement tools can produce in a comparable tribal health setting.

**AI-Powered Documentation — Opportunity and Risk** NextGen demonstrated Ambient Assist, an AI tool that listens to provider-patient conversations and generates structured clinical notes in real time. The efficiency gains are real — but so are the risks. Conference attendees from tribal health organizations noted that the tool does not reliably capture cultural aspects of clinical conversations, requiring providers to manually correct or add context specific to Native patients. Additionally, NextGen confirmed they are using multiple third-party AI foundation models — including commercial products — to power these tools. Patient conversation data processed through Ambient passes through that external infrastructure. This raises unresolved questions about consent, data handling, and compatibility with IHS data use agreements that NACA carries as a UIO.

**Data Integrity — Population Health Validation** A recurring theme across sessions was the importance of trusting your data before acting on it. NACA's HIM team presented a case where their population health platform was producing figures their staff did not trust — requiring a manual audit to reconcile.

**Operational Accountability — Workload Manager** The conference introduced NextGen's Workload Manager as a QI-adjacent tool: an automated task queue that converts procedures manual items into trackable, reportable workflows. The Task Analysis Report it generates shows completion rates by task type and by individual staff member — the kind of operational compliance data that supports peer review, performance improvement, and root cause analysis. When operational rules live in one person's head rather than in the system, quality is personality-dependent. When they live in the system, quality becomes auditable.

## Section 12: Safe Injection Practices

*CDC Injection Safety Checklist (Form 306089-G)*

| 8 Observations | 96% Compliance Rate | 5/6 Items at 100% | 1 Finding |
|---|---|---|---|

### Compliance by Item

*8 direct observations; N/A items not used in NACA's clinical model*

| | |
|---|---|
| ⚠ **Hand hygiene prior to medication admin — 87.5%**<br>Aseptic technique in clean area — 100%<br>One needle/syringe per patient — 100%<br>Alcohol disinfection of vial septum — 100%<br>New needle/syringe per vial entry — 100% | Single-dose vials for one patient only — 100%<br>Medication tubing/connectors per patient — N/A<br>Multi-dose vial dating & 28-day discard — N/A<br>Multi-dose vials dedicated per patient — N/A<br>Multi-dose vials in centralized area — N/A |

### Notable Finding

**Hand Hygiene (Obs. 5):** Observer noted "Gloves used" in lieu of hand hygiene. Per CDC standards, gloves do not substitute for hand hygiene — both are required. Classified as an education opportunity (1 of 8 observations, 12.5%). **Corrective action:** QI Director to coordinate brief staff education touchpoint with clinical lead; completion documented and reported at the June 2026 QIC meeting.

### Conclusion

Overall safe injection practice adherence is strong at 96%. All N/A responses reflect NACA's clinical model (no multi-dose vials or IV tubing in use), which itself eliminates common injection safety risks. The single gap identified has a clear corrective pathway. No systemic concerns were identified.

**Monthly Surveillance Round**

NACA NATIVE AMERICANS FOR COMMUNITY ACTION

## Month: May Year: 2026

| | Family Health Clinic | Behavioral Health | Wellness Center | Medical Records | GSA / Admin |
|---|---|---|---|---|---|
| Inspection Date/Standard | 5/28/2026 | 5/28/2026 | 5/28/2026 | 5/28/2026 | 5/28/2026 |
| A. Privacy & HIPPA compliant? | Y | Y | Y | Y | Y |
| B. Appropriate chemical use & disposal | Y | Y | Y | Y | Y |
| C. PPE & hand hygiene supplies readily available | N | Y | Y | Y | Y |
| D. Exam rooms, bathrooms, waiting rooms clean & organized? | N | N | N | Y | N |
| E. Medical equipment in good order? | N | Y | Y | N/A | N/A |
| F. All eyewash stations in good order? | N | N/A | N/A | N/A | N/A |
| G. Med room compliant, clear, organized? | N | N/A | N/A | N/A | N/A |
| I. Oxygen, first-aid, stat bag maintained & accessible | Y | N/A | N/A | N/A | N/A |
| J. Fire Extinguishers in good working order? | Y; Tag updated | Y; Tag updated | Y; Tag updated | Y; Tag updated | Y; Tag updated |
| K. Annual Inspection due date? | 7/8/2026 | 7/8/2026 | 7/8/2026 | 7/8/2026 | 7/8/2026 |
| L. Facility clear of hazards that could cause slips, trips, falls? | Y | Y | Y | Y | Y |
| M. Facility clear from hazards blocking paths of egress? | Y | N | Y | Y | Y |
| N. Exit Signs tested & in good working | Y | Y | N | N | Y |
| O. Emergency back-up lights in good working order? | Y | Y | Y | Y | Y |

| | | | | | |
|---|---|---|---|---|---|
| P. Exit doors unlocked? | Y | Y | Y | Y | Y |
| Q. Fire Door closed? | Y | N/A | N/A | N/A | N/A |
| R. Emergency Call Light battery (every 6 months) | 9/19/2025 changed | N/A | 9/19/2025 changed | N/A | N/A |
| S. Emergency Call Lights in good working order? | Y | N/A | Y | N/A | N/A |
| T. AED in good working order? | N | N/A | N | N/A | N |
| U. Automatic Doors in good working order? | **Y** | N/A | N/A | N/A | **Y** |
| Surveyor Initials | **FR** | **FR** | **FR** | **FR** | **FR** |
| Surveyor Name & Signature | | *Francisco Rendon 5/28/2026* | | | |

# Follow-Up Log

| ID | Building | Area | Category | Severity | Issue / what was found | Recommended action | Suggested owner | Date found | Status | Closed date |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Medical Records | Back bathroom | ADA / restroom | Deficiency | Toilet handle is on the wrong side and under-sink plumbing needs protective covers. | Correct toilet handle orientation and install protective covers under sink. | Facilities | 3/9/2026 | Open | |
| 5 | Hopi Conference Room | Main room | Life safety | Deficiency | No emergency light was observed in the room. | Verify code requirement and install or document existing emergency-light coverage. | Facilities | 3/9/2026 | Open | |
| 7 | Family Health Clinic | Back restroom | ADA / restroom | Deficiency | Soap dispenser and paper towels appear too high for wheelchair access. | Lower dispensers to ADA-accessible height. | Facilities | 3/9/2026 | Open | |
| 11 | Family Health Clinic | Second restroom | ADA / restroom | Deficiency | Soap and paper towel dispensers are too high; plumbing covering is present but looks shoddy. | Lower dispensers and improve/replace protective plumbing cover. | Facilities | 3/9/2026 | Open | |
| 11 | Family Health Clinic | Second restroom | ADA / restroom | Deficiency | Soap and paper towel dispensers are too high; plumbing covering is present but looks shoddy. | Lower dispensers and improve/replace protective plumbing cover. | Facilities | 3/9/2026 | Open | |
| 14 | Family Health Clinic | Office / cubicle area | Storage / housekeeping | Near Compliance | Extra items (including a sewing machine and miscellaneous materials) should be stored properly and general clutter reduced. | Remove nonessential items from cubicles/work areas and organize storage. | Dept. lead | 3/9/2026 | Open | |
| 16 | Family Health Clinic | Kitchen / break area | Utilities / documentation | Near Compliance | Need process/log for water purifier system and possibly for air-filter checks; some items need better labeling and organization. | Identify responsible party for purifier/filter maintenance; start a filter/log check process; label items more clearly. | Facilities / George / Clinic lead | 3/9/2026 | Open | |
| 17 | Family Health Clinic | Kitchen / refrigerator | Housekeeping | Near Compliance | Consider a fridge cleaning log; remove unneeded paper menus and improve organization. | Create fridge-cleaning signoff log and discard outdated/unneeded paper materials. | Clinic lead | 3/9/2026 | Open | |
| 23 | Family Health Clinic | Staff restroom | ADA / restroom | Deficiency | Toilet handle is on wrong side; soap and towel dispensers are too high; sink/vanity setup prevents accessible handwashing; plumbing needs covers. | Modify restroom for ADA access: handle orientation, dispenser heights, sink/vanity configuration, and plumbing protection. | Facilities | 3/9/2026 | Open | |
| 26 | Family Health Clinic | Patient restroom | ADA / restroom | Deficiency | Cabinet/furniture under sink should be removed, plumbing needs covers, emergency call cord is too low, and soap/paper towel dispensers should be lowered. | Remove cabinet, install covers, reset call cord height, and lower dispensers. | Facilities | 3/9/2026 | Open | |
| 32 | Family Health Clinic | Lobby | Administrative | Near Compliance | Staff photo display is missing/dated and should be updated after headshots. | Update lobby photo display. | Admin | 3/9/2026 | Open | |
| 35 | Wellness Center | Main room | Gym Equipment | Deficiency | TRX A frame needs to be bolted down per IHS recommendation | Contractor to bolt down A frame. | Facilities / Admin | 3/9/2026 | Open | |
| 37 | Behavioral Health | Lobby / wall surfaces | Facilities | Near Compliance | Wall chipping/holes need patching and repainting. | Patch damaged spots and repaint. | Facilities | 3/9/2026 | Open | |
| 37 | Behavioral Health | Lobby / wall surfaces | Facilities | Near Compliance | Wall chipping/holes need patching and repainting. | Patch damaged spots and repaint. | Facilities | 3/9/2026 | Open | |
| 43 | GSA / Admin | Storage room / cubicles | Storage | Near Compliance | Storage needs shelving and better organization; some items should move to storage unit; avoid storing items in cubicles if possible. | Add shelving, reorganize, and move nonessential items out of cubicles. | Admin / Facilities | 3/9/2026 | Open | |
| 44 | GSA / Admin | Reception records | Records management | Near Compliance | Old 2007-2008 finance department documents should be reviewed for retention/disposal. | Confirm retention requirement and archive or shred if allowed. | Admin | 3/9/2026 | Open | |
| 44 | GSA / Admin | Reception records | Records management | Near Compliance | Old 2007-2008 finance department documents should be reviewed for retention/disposal. | Confirm retention requirement and archive or shred if allowed. | Admin | 3/9/2026 | Open | |
| 48 | GSA / Admin | IT room | Facilities | Near Compliance | AC unit/rust-stained area should be cleaned up so it does not look like an active leak; vent is dusty. | Clean/repair stained surfaces and clean vent. | Facilities | 3/9/2026 | Open | |
| 49 | GSA / Admin | Restroom / hallway | ADA / restroom | Deficiency | Toilet handle is on wrong side; paper towel placement and hand sanitizer placement/replacement need attention; evacuation sign is bent/dinged. | Correct handle, adjust/replace sanitizer and towel setup, and replace bent sign if needed. | Facilities | 3/9/2026 | Open | |
| 49 | GSA / Admin | Restroom / hallway | ADA / restroom | Deficiency | Toilet handle is on wrong side; paper towel placement and hand sanitizer placement/replacement need attention; evacuation sign is bent/dinged. | Correct handle, adjust/replace sanitizer and towel setup, and replace bent sign if needed. | Facilities | 3/9/2026 | Open | |
| 51 | GSA / Admin | Dining area / refrigerator | Housekeeping / documentation | Near Compliance | Need a fridge cleaning signoff log and clear ownership for weekly clean-out. | Post and use a laminated fridge-cleaning log. | Admin | 3/9/2026 | Open | |
| 52 | GSA / Admin | Dining area / ice maker | Utilities / documentation | Near Compliance | Need process/log for ice maker or ice box filter changes and responsible person. | Document filter-change frequency, owner, and log. | Facilities / Admin | 3/9/2026 | Open | |
| 55 | GSA / Admin | Breakroom bulletin board | Posters / compliance | Deficiency | Minimum wage poster may be outdated for Flagstaff. | Verify required labor poster and replace if outdated. | HR / Admin | 3/9/2026 | Open | |
| 57 | Family Health Clinic | Lab / eyewash station | Equipment / safety | Deficiency | Eyewash station sticker is ripped; station expires September 2026. | Replace sticker and flag September 2026 expiration for timely renewal. | Facilities / Clinic lead | 4/22/2026 | Open | |
| 58 | Family Health Clinic | Lab area / hallway | Housekeeping / safety | Near Compliance | Lab transport box left in hallway outside lab — tripping hazard; staff previously reminded. | Reinforce: lab boxes must go directly to lab, not left in hallway. | Clinic lead | 4/22/2026 | Open | |
| 59 | Family Health Clinic | Utility / back area | Equipment | Near Compliance | Cast cutter left out unsecured; minor loose items that could be stored more efficiently. | Store cast cutter in labeled protective box; organize loose items. | Clinic staff / Facilities | 4/22/2026 | Open | |
| 60 | Family Health Clinic | Back door | Maintenance | Near Compliance | Back door latch sticks and requires rattling to close; Pete was previously notified. | Follow up with Pete to inspect and repair door latch. | Pete / Facilities | 4/22/2026 | Closed | |
| 61 | Family Health Clinic | Storage / refrigerator area | Facilities | Near Compliance | Refrigerator still elevated on 2x4s with metal cabinet — permanent solution needed. | Determine and implement proper permanent refrigerator placement. | Facilities | 4/22/2026 | Open | |
| 62 | Family Health Clinic | Custodial / signage | Administrative / compliance | Near Compliance | Rights and responsibilities signage is outdated (old version); staff photos also need updating. | Replace outdated rights & responsibilities signage and update staff photo display. | Admin / Clinic lead | 4/22/2026 | Open | |
| 64 | Family Health Clinic | HP cubicle area | Storage | Near Compliance | HP cubicles being used as storage due to space constraints. | Work with HP lead to reduce storage use in cubicle area. | Dept. lead | 4/22/2026 | Open | |
| 67 | Behavioral Health | IT room | Storage / access | Near Compliance | Boxes stored in IT room; IT team leaving items there despite it not being designated storage. | Notify IT team to clear boxes; reinforce storage policy. | IT / BH lead | 4/22/2026 | Open | |
| 68 | Behavioral Health | Back area | Safety | Near Compliance | Ladder found unsecured and left out in hallway area. | Store ladder in designated secured location when not in use. | Facilities | 4/22/2026 | Open | |
| 73 | Wellness Center | Offices / lighting | Maintenance | Near Compliance | Lighting in some offices appears dim or flickering; staff noted lights going in and out. | Have facilities evaluate and replace dim or faulty bulbs. | Facilities | 4/22/2026 | Open | |
| 75 | GSA / Admin | Back room / electrical panel | Electrical / access | Deficiency | Electrical panel in back room cannot be opened — key is missing; panel must remain accessible. | Locate key or arrange access to panel for inspection compliance. | Facilities | 4/22/2026 | Open | |
| 76 | GSA / Admin | Back door | Maintenance | Near Compliance | Back door has significant wiggle / looseness. | Have Pete or facilities inspect and tighten/repair back door. | Pete / Facilities | 4/22/2026 | Closed | |
| 78 | GSA / Admin | Front common area | Administrative | Near Compliance | Unidentified personal item (hat/bag) left in common area for approximately two weeks — owner unknown. | Discard or relocate unclaimed item; remind staff about personal items in shared spaces. | Admin | 4/22/2026 | Closed | |
| 81 | Medical Records | Office area | Equipment / IT | Near Compliance | Front desk computer needs privacy screens. | Submit IT request for replacement monitors for Debbie. | IT / Dept. lead | 4/22/2026 | Open | |
| 82 | Medical Records | Office / wall area | Facilities | Near Compliance | One board/panel cracked with escucheon visible. | Repair or replace cracked board/panel. | Facilities | 4/22/2026 | Open | |
| 83 | Medical Records | Exit signs | Life safety | Near Compliance | Exit signs annual inspection due July 2026 — monitor and schedule before due date. | Schedule exit sign inspection before July 2026. | Facilities | 4/22/2026 | Open | |
| 84 | Family Health Clinic | Lab | Infection Control / Supply | Deficiency | Missing soap in lab handwashing station (IC audit finding). | Restock soap immediately; add to daily supply checklist. | Clinic lead / Facilities | 2026-05-28 0:00:00 | Open | |
| 85 | Family Health Clinic | Vaccine/Medication Room | Infection Control / Supply | Deficiency | Missing soap in medication/vaccine room handwashing station (IC audit finding). | Restock soap; verify all handwashing stations stocked during daily rounds. | Clinic lead / Facilities | 2026-05-28 0:00:00 | Open | |
| 86 | Family Health Clinic | Multiple exam rooms / lab / vaccine room | Infection Control / Compliance | Deficiency | Expired or misdated supplies: gloves in lab, needles in vaccine room, glucose strips & control solution in retinopathy room, goggles in Exam 6 & 7, speculum box | Remove and replace all expired items; update labeling. Nursing staff to complete sweep and log corrections. | Nursing / Clinic lead | 2026-05-28 0:00:00 | Open | |
| 87 | Family Health Clinic | Med/Lab Area | Infection Control / Safety | Near Compliance | OSHA clearance tape around electrical box/window removed during repainting — area must remain clear per OSHA requirement. | Replace floor tape marking the OSHA clearance area around the electrical box/window. | Facilities / FR | 2026-05-28 0:00:00 | Open | |
| 88 | Family Health Clinic | Lab | Equipment / Safety | Near Compliance | Eyewash station sticker ripped (carryover); station expires September 2026. Monthly eyewash checks not consistently performed. | Replace sticker; confirm eyewash station on monthly inspection log; schedule replacement before Sept 2026. | Facilities / Clinic lead | 2026-05-28 0:00:00 | Open | |
| 89 | Family Health Clinic | Utility / Electrical Panel | Maintenance / Safety | Deficiency | Electrical panel switches secured with makeshift tape already peeling loose — unprofessional and potentially non-compliant. | Await report from Dan Herder; evaluate proper locking mechanism per electrical safety standard. | FR / Facilities | 2026-05-28 0:00:00 | Open | |
| 90 | All Buildings | Break areas / Kitchens | Housekeeping | Near Compliance | Microwaves with debris in BH, FHC, WC; BH refrigerators x2 with debris; food not labeled/dated in BH/FHC/WC/GSA (IC audit finding). | Issue staff reminder for food labeling; add microwave/fridge cleaning to weekly checklist; dept. leads to verify. | Dept. leads / Clinic leads | 2026-05-28 0:00:00 | Open | |
| 91 | Wellness Center | Ceiling | Facilities / Maintenance | Near Compliance | Two stained ceiling tiles observed in Wellness Center (IC audit finding). | Facilities to evaluate tiles for moisture/mold source and replace. | Facilities / FR | 2026-05-28 0:00:00 | Open | |
| 92 | Family Health Clinic | Exterior / Fence Area | Housekeeping / Facilities | Near Compliance | Fence cleaning status uncertain — unclear if appearance is normal wear or dirt buildup. Marvin's team to test with duster. | Marvin's team to complete test clean and report findings to FR. | Marvin / Facilities | 2026-05-28 0:00:00 | Open | |
| 93 | Family Health Clinic | Supply / Clinical Area | Infection Control | Near Compliance | Bulk gauze packaging in use — creates contamination risk if staff access shared supply with unclean hands. | Replace bulk gauze with individual single-use packets per IC best practice. | Nursing / Clinic lead | 2026-05-28 0:00:00 | Open | |
| 94 | Family Health Clinic | IT / Electronics | Equipment / Housekeeping | Near Compliance | Electronic equipment (keyboards, monitors) cleaning protocol unclear — staff told not to clean due to damage risk. | Identify approved electronic-safe wipes/dusters; communicate protocol to Marvin's team and staff. | Facilities / IT | 2026-05-28 0:00:00 | Open | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 95 | Family Health Clinic | Patient Area | Equipment / Technology | Near Compliance | iPad charging stations outdated (old connectors); patients expected to complete LUMA tasks on personal phones. No compliant patient charging available. | Explore rearranging chairs near existing outlets; obtain cost estimate for updated charging stations before capital request. | Verity / Admin | 2026-05-28 0:00:00 | Open | |
| 96 | Medical Records | Badge Access | Security / IT | Near Compliance | Medical records badge access issues ongoing (carryover from April rounds). | Follow up with IT to resolve badge access. | IT / MedRec lead | 2026-05-28 0:00:00 | Open | |
| 97 | Medical Records | Storage | Housekeeping / Supply | Near Compliance | Copy paper stored in cardboard box on floor in medical records (IC audit finding). | Move copy paper off floor; store on shelving. | MedRec lead | 2026-05-28 0:00:00 | Open | |
| 98 | Behavioral Health | Patient Care Room | Infection Control / Equipment | Near Compliance | BH massage chair torn at foot rests (IC audit finding). | Replace or repair massage chair; document corrective action. | BH lead | 2026-05-28 0:00:00 | Open | |

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

Major Highlights:

- Tribal User Group Meeting May 2026
- Dr. Chadd Nelson obtained his Arizona License
- Outpatient Coder Interview Scheduled
- Biller, Billing Program Manager vacancies Posted
- Performance Evaluations Completed
- Hire of Consultant, Laura Wood for Billing/Coding Review
- 2026 SMPR
- Upcoming Mammogram Bus Event: June 16

Major Challenges:

- Provider stability, decrease # of overall FHC visits
- Provider Recruitment
- Workload / Balance
- Limited uninterrupted time to work due to Meeting volume
- 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)
- NACA Turnover
- Executive Leadership Change
- Luma Hiccups

Staffing updates:

- Dr Nelson formal offer, anticipate start mid-July 2026 (13th or 20th)
- Resume Physician Recruitment Summer 2026
- Verity to provider supervision to PSCs, and PBC interim assignment

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

## GPRA: Oct 1, 2025- June 8, 2026

| 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% | 45.59% | 41.38% |
| Adult Immunizations - Shingrix GPRA 2025 | 39.0% | 30.68% | 32.81% |
| Adult Immunizations - TDaP GPRA 2025 | 39.0% | 29.08% | 27.82% |
| Adult Immunizations Comprehensive GPRA 2025 | 39.0% | 25.02% | 24.01% |
| Adult Immunizations TDaP/Td GPRA 2025 | 39.0% | 25.11% | 23.93% |
| Adult Influenza Immunization GPRA 2025 | 21.0% | 11.65% | 6.69% |
| Alcohol Screening GPRA 2025 | 36.0% | 45.82% | 35.36% |
| Cancer Screening: Mammogram Rates GPRA 2025 | 40.0% | 33.66% | 26.96% |
| Cervical Cancer Screening GPRA 2025 | 35.0% | 14.93% | 14.12% |
| Child Influenza Immunization GPRA 2025 | 18.0% | 13% | 8.79% |
| Childhood Weight Control GPRA 2025 | 22.0% | 100% | 100% |
| Colorectal Cancer Screening GPRA 2025 | 24.0% | 9.27% | 9.66% |
| Controlling High Blood Pressure (Million Hearts) GPRA 2025 | 48.0% | 34.48% | 48.25% |
| Dental Sealants GPRA 2025 | 11.0% | 1.52% | 0% |
| Depression Screening: Age 18 yrs and older GPRA 2025 | 39.0% | 47.45% | 32.13% |
| Depression Screening: Ages 12-17 yrs GPRA 2025 | 36.0% | 57.69% | 47.95% |
| Diabetes Glycemic Control GPRA 2025 | 12.0% | 33.78% | 32.35% |
| Diabetes: Blood Pressure Control GPRA 2025 | 57.0% | 66.22% | 70.59% |
| Diabetes: Nephropathy Assessment GPRA 2025 | 44.0% | 27.03% | 42.65% |
| Diabetic Retinopathy GPRA 2025 | 47.0% | 28.38% | 44.12% |
| HIV Screening GPRA 2025 | 42.0% | 3% | 2.94% |
| Intimate Partner & Domestic Violence (IPV/DV) Exam GPRA 2025 | 30.0% | 12.05% | 11.61% |
| Screening, Brief Intervention, and Referral to Treatment (SBIRT) GPRA 2025 | 15.0% | 0% | 0% |
| Statin Therapy for the Prevention and Treatment of Cardiovascular Disease GPRA 2025 | 36.0% | 33.64% | 37.59% |
| Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes GPRA 2025 | 52.0% | 100% | 100% |
| Tobacco Cessation GPRA 2025 | 27.0% | 14.71% | 14.11% |
| Tobacco Use and Exposure Assessment: Screening GPRA 2025 | 50.0% | 45.17% | 32.44% |
| Tobacco Use and Exposure Assessment: Tobacco Use GPRA 2025 | 50.0% | 41.24% | 28.02% |
| Topical Fluoride GPRA 2025 | 27.0% | 0% | 0% |

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

Infection Control:

- Microorganism Report (see attached)
- Culture Report (see attached)
- Measles Awareness

Employee Health:

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 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

Luma:

- All Luma components are live and transitioning to support **except eligibility**, which is still in progress.
    - Weekly implementation calls will end; eligibility will remain active until setup and testing are complete.
- Eligibility:
    - Final setup is in progress (Marvin, Alli, Jillian).
    - A batch payment test will be completed before go-live.
    - Front desk training will be scheduled once ready, as they will run eligibility checks.
    - Deborah (primary) and Cassie (backup) are main contacts going forward.
- Key System Issues

  - Data write-back (Luma → NextGen): Privacy, consent, insurance, address, and other patient data are not transferring.
    - Temporary workaround: manual entry required.
    - Team is restarting API/Rosetta agents; if unresolved, a support case will be opened.
- Pharmacy lookup limitations:
  - Relies on Google API; some pharmacies (e.g., Sacred Peaks) are not searchable.
  - Manual entry required when not found.
  - Enhancement request submitted (no timeline).
- Address limitations:
  - Suite/apartment numbers do not write back.
  - Workaround: capture via free-text form fields.
- Analytics & Support
  - Since May 12:
    - 846 forms completed
    - 53% patient engagement
    - 3,000+ patient messages (mostly SMS)
    - Support tickets handled via NextGen; resources available in Help Center and Success Community.
- Staffing Updates
  - Both added to support tickets for continuity.
    - Next Steps / Action Items
      - Finalize eligibility setup and schedule staff training.
      - Monitor and resolve write-back issues.
      - Continue advocacy for pharmacy lookup enhancement.
      - Update patient forms (e.g., tribal affiliation, blood quantum codes).

2026 Pending Projects/Plans/Goals

- PCMH QI Study
- No Shows Performance Improvement
- Close Referrals / Open Orders - QI Study/Performance Improvement

Committee/Meeting Involvement:

  - Need to build in front desk & Billing/Coding Consultant meetings; 78 meetings in ~4.5 weeks is extremely high volume, ~156 estimated hours tied to meetings , Nearly half are recurring ; Work is heavily split across operations, compliance, and systems

- June 1 HP Team Meeting
- June 1 SMPR Planning Meeting
- June 2 AAPC weekly meeting
- June 2 TPWIC check in meeting
- June 2 TempDev check in meeting
- June 2 NACA Pop Health monthly meeting
- June 3 DOO-CEO Meeting
- June 3 Site Management meeting with custodians
- June 3 IMH Luma Meeting
- June 3 SMPR Ramada Crew Review meeting
- June 3 Equality Health Monthly Risk/Quality Review
- June 3 CIC Study Group (IHS)
- June 3 Meet N Greet BCBS
- June 3 FHC/CFO exit meeting
- June 4 QI/C monthly meeting
- June 4 MedExec quarterly meeting
- June 4 HP/CFO exit meeting
- June 4 Modio Warm Hand off meeting
- June 4 Leadership meeting
- June 4 Relias implementation meeting
- June 4 WCAG Accessibility Compliance Review
- June 5 XpertDox Update meeting
- June 5 TempDev Check in
- June 5: PBC Check in
- June 8: Luma Check in meeting
- June 8 HP Team meeting
- June 8: TAPI Provider Education Committee Meeting
- June 8: Fitness Specialist interview
- June 9: Kinney Site Walk for renovations
- June 9: Loven Site Walk for renovations
- June 9: AAPC Weekly Meeting (overlaps with Grants)
- June 9: IMO Demo with Kyte
- June 10: QI/DOO Meeting

- June 10: High Caliber Construction Site Walk for renovations
- June 10: Relias Compliance Management Kick off
- June 11: Outpatient Coder Interview
- June 11: Instamed Administrative Update Meeting
- June 11: CMS AIAN QIO Meeting
- June 11: Directors Meeting
- June 11: Front Desk/PBC/Biller Team Meeting
- June 12: AZ Complete Health Monthly Meeting
- June 15: Luma Meeting
- June 15: HP Team Meeting
- June 16: Grants Committee Meeting
- June 16: AAPC Meeting (overlaps with Grants)
- June 16: Mammogram Bus Event
- June 17: CEO DOO Meeting
- June 17: NG Pop Health User group meeting
- June 17: CHR Subcommittee Meeting
- June 17: IHS Safety Hour
- June 17: CIC Study Group
- June 17: NACA AIAN QIO Meeting
- June 17: Board of Directors Meeting
- June 18: AZHDR Onboarding Training for all clinical staff
- June 18: All clinic staff meeting (measles drill)
- June 18: DUIA Urban Program Meeting
- June 18: Leadership Meeting (overlaps with DUIA)
- June 18: Glycemic Control Subcommittee Meeting
- June 18: Navajo Area National Data Warehouse Discussion Meeting
- June 18: NACA AZCH Meeting (Billing/Coding Review)
- June 22: Luma Meeting
- June 22: DOO FHC Meeting
- June 22: HP Team Meeting
- June 22: DOO HP Meeting
- June 23: AAPC Weekly Meeting
- June 23: DOO QI Meeting

- June 23: THNC General Committee Meeting
- June 23: TPWIC COP Save the Date
- June 24: CIC Study Group Meeting
- June 24-27: Roots 2026 Conference
- June 25: Nurse Staff Meeting (will miss)
- June 25: QI/C Meeting (will miss)
- June 25: AZCH Northern Arizona Tribal Collaboration Meeting (will miss)
- June 25: IHS Infection Control Hours (will miss)
- June 25: Directors Meeting (will miss)
- June 26: Equality Health Monthly check in (will reschedule)
- June 29: Luma Meeting
- June 29: HP Team Meeting
- June 30: Grants committee meeting
- June 30: Tribal CHR Directors monthly meeting
- June 30: AAPC weekly meeting
- July 1: CEO-DOO Meeting
- July 1: CIC Study Group
- July 2: Leadership meeting

Travel:

- Verity to CHW Summit June 24-27 2026 in Chandler AZ
- Verity & Shay to National Tribal Health Conference Aug 2026 in Chandler, AZ
- Nextgen UGM Annual Conference – Nov 8-12 in San Diego, CA

Attachments:

- Fonemed Report
- Urban and 1ALOE Reports
- Microorganisms Report
- Culture Report
- Ashline Referrals
- Equality Health Q1 2026 Report

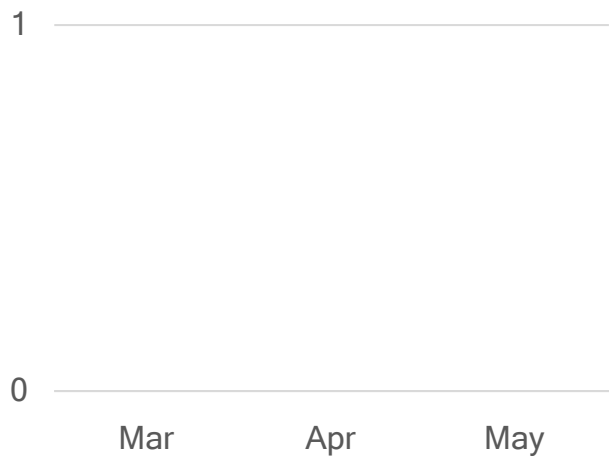
# May 2026 ASHLine Referral Status Report

## Native Americans for Community Action (NACA)

0

| | |
|---|---|
| Validated Referrals: | 0% |
| Reach Rate: | 0% |
| Conversion Rate: | 0% |

## Number of Referrals




Overall number of referrals in Arizona for May 2026 was 175.

**Patient Care Tip:** Tobacco use results in more preventable deaths than any other one factor. Refer your patients to the ASHLine today to help them live longer lives.

**Key Resources:**

Arizona QuitLogix Health Professionals Resource Page
https://ashline.quitlogix.org/en-US/Health-Professionals/Resources
Quitlogix Education for Arizona Providers
https://quitlogixeducation.org/arizona/

**Definitions:**

**Referrals:** Received referrals and outreach to the participant has been completed. Note: The number of closed referrals may not align with the number of referrals sent.

**Validated Referrals**: Received referrals that have complete and accurate contact information to conduct outreach. A rate less than 100% means the referral was missing data resulting in no participant contact. (Intake Only + Enrolled + Declined + Unreachable)/Closed)

**Reach Rate:** Percent of participants with whom we were able to connect during outreach. (Intake Only + Enrolled + Declined) /Validated)

**Conversion Rate:** Percent of participants who have completed an intake and/or enrolled in the program. (Intake Only + Enrolled/Reach)

**Please contact healthsystemschange@njhealth.org to let us know who the best person is to receive this report at your organization. Kindly include their name and email address. If you have any questions about this report, please email or call us at 844-251-0006.**

# Equality Care Incentive Program (ECIP) | 2026

EQUALITY HEALTH

Native Americans for Community Action Payment Quarter: 2026Q1

## Medicaid Adults

| Category | Measure | Eligible Activities[1] | Payable Activities[2] | Activities Marked for Closure[3] | Earnings Per Payable Activity | Earnings |
|---|---|---|---|---|---|---|
| P&S | CCS | 302 | 72 | 12 | $10 | $720 |
| TOC | FUH7 | | | | $100 | $0 |
| TOC | ADT-IP | 4 | | 1 | $100 | $0 |
| CCM | CCM | 34 | 2 | 2 | $100 | $200 |
| **Total** | | | | | | **$920** |

## Medicaid Kids

| Category | Measure | Eligible Activities[1] | Payable Activities[2] | Activities Marked for Closure[3] | Earnings Per Payable Activity | Earnings |
|---|---|---|---|---|---|---|
| Wellness | W15 | 66 | 1 | | $120 | $120 |
| Wellness | W30 | 24 | 1 | | $30 | $30 |
| Wellness | WCV | 297 | 6 | | $30 | $180 |
| P&S | CIS | 89 | 1 | | $10 | $10 |
| P&S | WCC-NUT | 239 | 1 | | $10 | $10 |
| TOC | FUH7 | 1 | | | $100 | $0 |
| TOC | ADT-IP | | | | $100 | $0 |
| **Total** | | | | | | **$350** |

## FFS

| Category | Measure | Eligible Activities[1] | Payable Activities[2] | Activities Marked for Closure[3] | Earnings Per Payable Activity | Earnings |
|---|---|---|---|---|---|---|
| Wellness | AAWV | 232 | | 1 | $100 | $0 |
| Wellness | RAF | 163 | 1 | | $20 | $20 |
| TOC | FUH7 | | | | $100 | $0 |
| TOC | ADT-IP | 1 | | | $100 | $0 |
| CCM | CCM | 37 | 1 | 2 | $100 | $100 |
| **Total** | | | | | | **$120** |

## DSNP

| Category | Measure | Eligible Activities[1] | Payable Activities[2] | Activities Marked for Closure[3] | Earnings Per Payable Activity | Earnings |
|---|---|---|---|---|---|---|
| Wellness | AAWV | 1 | | | $150 | $0 |
| Wellness | RAF | | | | $20 | $0 |
| P&S | CCS | | | | $10 | $0 |
| P&S | KED | 1 | | | $10 | $0 |
| P&S | COL | | | | $10 | $0 |
| TOC | FUH7 | | | | $100 | $0 |
| TOC | ADT-IP | | | | $100 | $0 |
| CCM | CCM | | | | $100 | $0 |
| **Total** | | | | | | **$0** |

[1]An Eligible Activity is any activity attributed to a provider that meets the ECIP measure criteria for the quarter.

[2]A Payable Activity is any activity closed by Claims, Quality, or Marked For Closure.

[3]Activity Marked for Closure is any activity that has been Marked for Closure in CareEmpower, or via EHR data, and will be payable when confirmed with claims or after 180 days have passed. Note that this may include activities with open requirements; please consult your Patient Detail report for further information

For detailed information and requirements, refer to the ECIP Reference Guide.

| Quarterly Payment | Amount |
|---|---|
| Payable Activities | $1,390 |
| Less Adjustments | $0 |
| Final Payment | $1,390 |

**NACA**
**1500 E Cedar Ave**
**Suite 26**
**Flagstaff, AZ 86004**

Sonora Quest Laboratories®

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

**Account: 76050**

Report Date: 06/01/2026 02:40 AM

Approval Date Range: **05/01/2026 - 05/31/2026**

# Client Cultures Report

## NACA

| Patient Name | Patient ID | Coll. Date | Physician Name | Order Number |
|---|---|---|---|---|
| [redacted] | 64affd42bb12653fdb60a786 | 03/19/2026 | Smith Mary Sylvia FNP | 76050-PRO43431 |
| **Culture, Urine** | | **Result** | | |
| Mixed Gram positive and Gram negative flora | | 50,000 - 100,000 CFU/mL | | |
| **Patient Name** | **Patient ID** | **Coll. Date** | **Physician Name** | **Order Number** |
| [redacted] | 64af317778a9bc1e6dcf8a85 | 04/07/2026 | DavisBegay Rhonda P FNP | 76050PRO44122 |
| **Culture, Urine** | | **Result** | | |
| Escherichia coli | | >100,000 CFU/mL | | |
| Ampicillin | | S 4 | | |
| Augmentin | | S <=2 | | |
| Ciprofloxacin | | S <=0.06 | | |
| Ceftriaxone | | S <=0.25 | | |
| Cefazolin | | S <=1 | | |
| Cefazolin (Uncomplicated Urine) | | S <=1 | | |
| ESBL | | Neg Neg | | |
| Nitrofurantoin | | S <=16 | | |
| Levofloxacin | | S <=0.12 | | |
| Trimetho/Sulfa | | R >=320 | | |
| Tobramycin | | S <=1 | | |
| **Patient Name** | **Patient ID** | **Coll. Date** | **Physician Name** | **Order Number** |
| [redacted] | 64af2fc968cced70dc051e40 | 04/20/2026 | DavisBegay Rhonda P FNP | 76050-PRO44657 |
| **Culture, Urine** | | **Result** | | |
| Mixed Gram positive flora | | 10,000 - 50,000 CFU/mL | | |
| **Patient Name** | **Patient ID** | **Coll. Date** | **Physician Name** | **Order Number** |
| [redacted] | 64af50eb4f66be4c929e73d1 | 05/20/2026 | Deboard Ruth A FNP | 76050-PRO45278 |
| **Culture, Group A Strep** | | **Result** | | |
| Negative | | . | | |
| **Patient Name** | **Patient ID** | **Coll. Date** | **Physician Name** | **Order Number** |
| [redacted] | 64af50eb4f66be4c929e73d1 | 05/20/2026 | Deboard Ruth A FNP | 76050-PRO45277 |
| **Culture, Urine** | | **Result** | | |
| Mixed Gram positive flora | | 10,000 - 50,000 CFU/mL | | |
| **Patient Name** | **Patient ID** | **Coll. Date** | **Physician Name** | **Order Number** |

| [redacted] | 64af348888db714162a848b0 | 04/03/2026 | DavisBegay Rhonda P FNP | 76050PRO44076 |
|---|---|---|---|---|

| Culture, Urine | Result |
|---|---|
| Escherichia coli | 50,000 - 100,000 CFU/mL |
| Ampicillin | S <=2 |
| Augmentin | S <=2 |
| Ciprofloxacin | S <=0.06 |
| Ceftriaxone | S <=0.25 |
| Cefazolin | S 2 |
| Cefazolin (Uncomplicated Urine) | S 2 |
| ESBL | Neg Neg |
| Nitrofurantoin | S <=16 |
| Levofloxacin | S <=0.12 |
| Trimetho/Sulfa | S <=20 |
| Tobramycin | S <=1 |

| Patient Name | Patient ID | Coll. Date | Physician Name | Order Number |
|---|---|---|---|---|
| [redacted] | 64af376d9ff1d2749899fb56 | 04/16/2026 | DavisBegay Rhonda P FNP | 76050PRO44400 |

| Culture, Urine | Result |
|---|---|
| No growth | . |

| Patient Name | Patient ID | Coll. Date | Physician Name | Order Number |
|---|---|---|---|---|
| [redacted] | 64af43d60db0fc17fdba2ac6 | 05/28/2026 | Arhin Akwasi MD | 76050PRO45388 |

| Culture, Urine | Result |
|---|---|
| Escherichia coli | 50,000 - 100,000 CFU/mL |
| Ampicillin | R >=32 |
| Augmentin | S 4 |
| Ciprofloxacin | S 0.25 |
| Ceftriaxone | S <=0.25 |
| Cefazolin | I 4 |
| Cefazolin (Uncomplicated Urine) | S 4 |
| ESBL | Neg Neg |
| Nitrofurantoin | S <=16 |
| Levofloxacin | S 0.5 |
| Cefuroxime - sodium | S 4 |
| Cefuroxime - axetil | S 4 |
| Trimetho/Sulfa | S <=20 |
| Tobramycin | S <=1 |

| Patient Name | Patient ID | Coll. Date | Physician Name | Order Number |
|---|---|---|---|---|
| [redacted] | 64affdd8d568155bdfeddb17 | 05/08/2026 | Arhin Akwasi MD | 76050-PRO44950 |

| Culture, Urine | Result |
|---|---|
| Escherichia coli | 10,000 - 50,000 CFU/mL |
| Ampicillin | R >=32 |
| Ciprofloxacin | S <=0.06 |
| Ceftriaxone | S <=0.25 |
| Cefazolin | R >=32 |
| Cefazolin (Uncomplicated Urine) | R >=32 |
| Nitrofurantoin | S <=16 |
| Levofloxacin | S <=0.12 |
| Cefuroxime - axetil | I 16 |
| Tobramycin | S <=1 |
| ESBL | Neg Neg |
| Augmentin | R >=32 |

| | |
|---|---|
| Trimetho/Sulfa | S <=20 |
| Cefuroxime - sodium | I 16 |

| Patient Name | Patient ID | Coll. Date | Physician Name | Order Number |
|---|---|---|---|---|
| [redacted] | 67ed61a0a0f2c1259a9d128b | 05/27/2026 | Arhin Akwasi MD | 76050-PRO45366 |

| Culture, Urine | Result |
|---|---|
| Klebsiella pneumoniae | >100,000 CFU/mL |
| Ampicillin | R >=32 |
| Augmentin | S <=2 |
| Ciprofloxacin | S <=0.06 |
| Ceftriaxone | S <=0.25 |
| Cefazolin | I 4 |
| Cefazolin (Uncomplicated Urine) | S 4 |
| ESBL | Neg Neg |
| Nitrofurantoin | I 64 |
| Levofloxacin | S <=0.12 |
| Cefuroxime - sodium | S 8 |
| Cefuroxime - axetil | I 8 |
| Trimetho/Sulfa | S <=20 |
| Tobramycin | S <=1 |

| Patient Name | Patient ID | Coll. Date | Physician Name | Order Number |
|---|---|---|---|---|
| [redacted] | 64af2d526f21973a9eae0c83 | 04/03/2026 | DavisBegay Rhonda P FNP | 76050-PRO44009 |

| Culture, Urine | Result |
|---|---|
| No growth | . |

| Patient Name | Patient ID | Coll. Date | Physician Name | Order Number |
|---|---|---|---|---|
| [redacted] | 64afae99441cf975f38917e6 | 04/03/2026 | DavisBegay Rhonda P FNP | 76050-PRO44079 |

| Culture, Urine | Result |
|---|---|
| No growth | . |

| Patient Name | Patient ID | Coll. Date | Physician Name | Order Number |
|---|---|---|---|---|
| [redacted] | 67b6ce6949bbef730f50873f | 04/22/2026 | Arhin Akwasi MD | 76050-PRO44760 |

| Culture, Urine | Result |
|---|---|
| Escherichia coli | >100,000 CFU/mL |
| Ampicillin | R >=32 |
| Augmentin | S 4 |
| Ciprofloxacin | S <=0.06 |
| Ceftriaxone | S <=0.25 |
| Cefazolin | S 2 |
| Cefazolin (Uncomplicated Urine) | S 2 |
| ESBL | Neg Neg |
| Nitrofurantoin | S <=16 |
| Levofloxacin | S <=0.12 |
| Trimetho/Sulfa | R >=320 |
| Tobramycin | S <=1 |

| Patient Name | Patient ID | Coll. Date | Physician Name | Order Number |
|---|---|---|---|---|
| [redacted] | 64af52b8781e3c1f7d2cd092 | 04/22/2026 | Smith Mary Sylvia FNP | 76050-PRO44761 |

| Culture, Urine | Result |
|---|---|
| Escherichia coli | 50,000 - 100,000 CFU/mL |
| Augmentin | S <=2 |
| Cefazolin | S <=1 |
| Cefazolin (Uncomplicated Urine) | S <=1 |
| ESBL | Neg Neg |
| Levofloxacin | I 1 |
| Ceftriaxone | S <=0.25 |

| | |
|---|---|
| Ciprofloxacin | S 0.25 |
| Ampicillin | S <=2 |
| Nitrofurantoin | S <=16 |
| Tobramycin | S <=1 |
| Trimetho/Sulfa | S <=20 |

| Patient Name | Patient ID | Coll. Date | Physician Name | Order Number |
|---|---|---|---|---|
| [redacted] | 64af971efb01df1ac102edd2 | 04/16/2026 | DavisBegay Rhonda P FNP | 76050-PRO44537 |

| Culture, Urine | Result |
|---|---|
| Escherichia coli | 50,000 - 100,000 CFU/mL |
| Ampicillin | R >=32 |
| Augmentin | I 16 |
| Ciprofloxacin | S <=0.06 |
| Ceftriaxone | S <=0.25 |
| Cefazolin | R 8 |
| Cefazolin (Uncomplicated Urine) | S 8 |
| ESBL | Neg Neg |
| Nitrofurantoin | S <=16 |
| Levofloxacin | S <=0.12 |
| Cefuroxime - sodium | S 4 |
| Cefuroxime - axetil | S 4 |
| Trimetho/Sulfa | R >=320 |
| Tobramycin | S <=1 |

| Patient Name | Patient ID | Coll. Date | Physician Name | Order Number |
|---|---|---|---|---|
| [redacted] | 64af3fc788653d636be6da06 | 05/27/2026 | Smith Mary Sylvia FNP | 76050-PRO45364 |

| Culture, Urine | Result |
|---|---|
| No growth | . |

| Patient Name | Patient ID | Coll. Date | Physician Name | Order Number |
|---|---|---|---|---|
| [redacted] | 64af6c6b70373f626c3088fa | 05/12/2026 | Smith Mary Sylvia FNP | 76050-PRO45098 |

| Culture, Urine | Result |
|---|---|
| No growth | . |

| Patient Name | Patient ID | Coll. Date | Physician Name | Order Number |
|---|---|---|---|---|
| [redacted] | 64af6712e5af555a8d76710a | 04/10/2026 | Smith Mary Sylvia FNP | 76050-PRO44310 |

| Culture, Urine (Reflex) | Result |
|---|---|
| Mixed Gram positive flora | 10,000 - 50,000 CFU/mL |

| Patient Name | Patient ID | Coll. Date | Physician Name | Order Number |
|---|---|---|---|---|
| [redacted] | 64af6712e5af555a8d76710a | 04/21/2026 | Smith Mary Sylvia FNP | 76050PRO44686 |

| Culture, Urine | Result |
|---|---|
| No growth | . |

**NACA**
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**Suite 26**
**Flagstaff, AZ 86004**

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602.685.5000 or 800.766.6721

**Account: 76050**

Report Date: 06/01/2026 12:03 PM

Approval Date Range: **05/01/2026 - 05/31/2026**

# Microorganisms Summary Report

**NACA**

**Culture Type: Urine**

| Microorganism | Total |
|---|---|
| Escherichia coli | 2 |
| Mixed Gram positive flora | 1 |
| Klebsiella pneumoniae | 1 |

FONEMED

A HEALTHIER TOMORROW

# Complete Call Report

## Native Americans for Community Action (NACA)

February 2026

Please contact us with any questions by phone or email.

**The FONEMED Team**

# 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 |

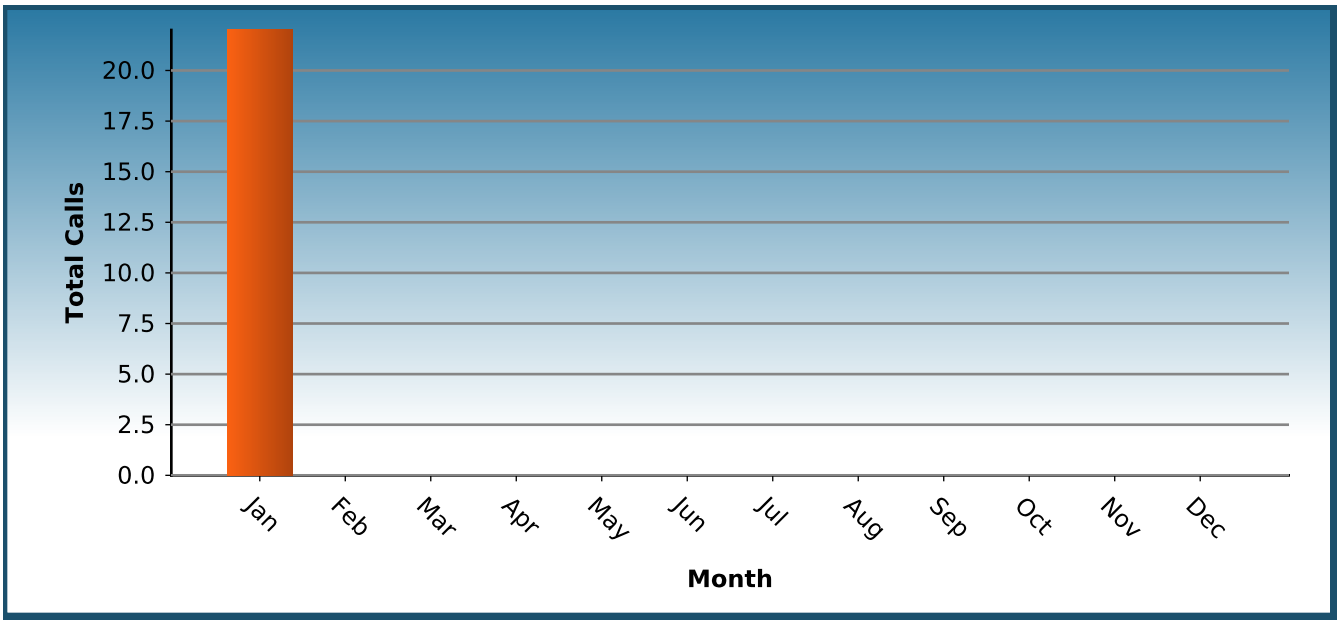
*Estimated National Averages for Health Care Services:

| | |
|---|---|
| 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

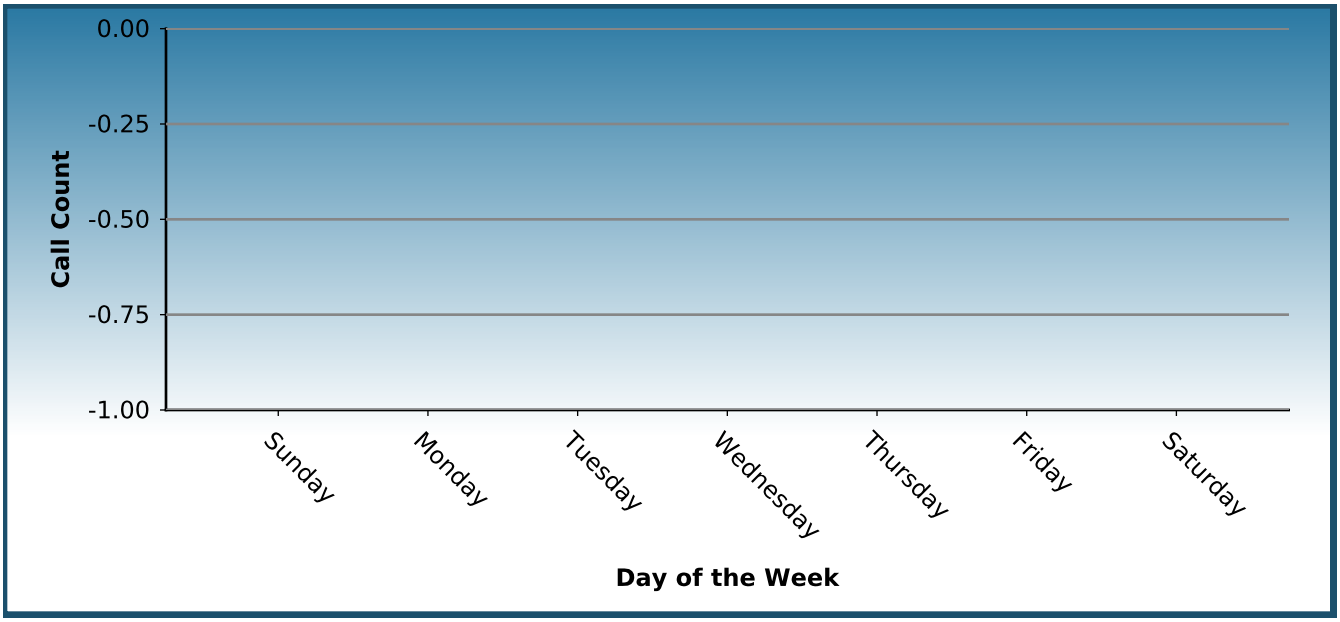
# Calls By Month

| 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 |



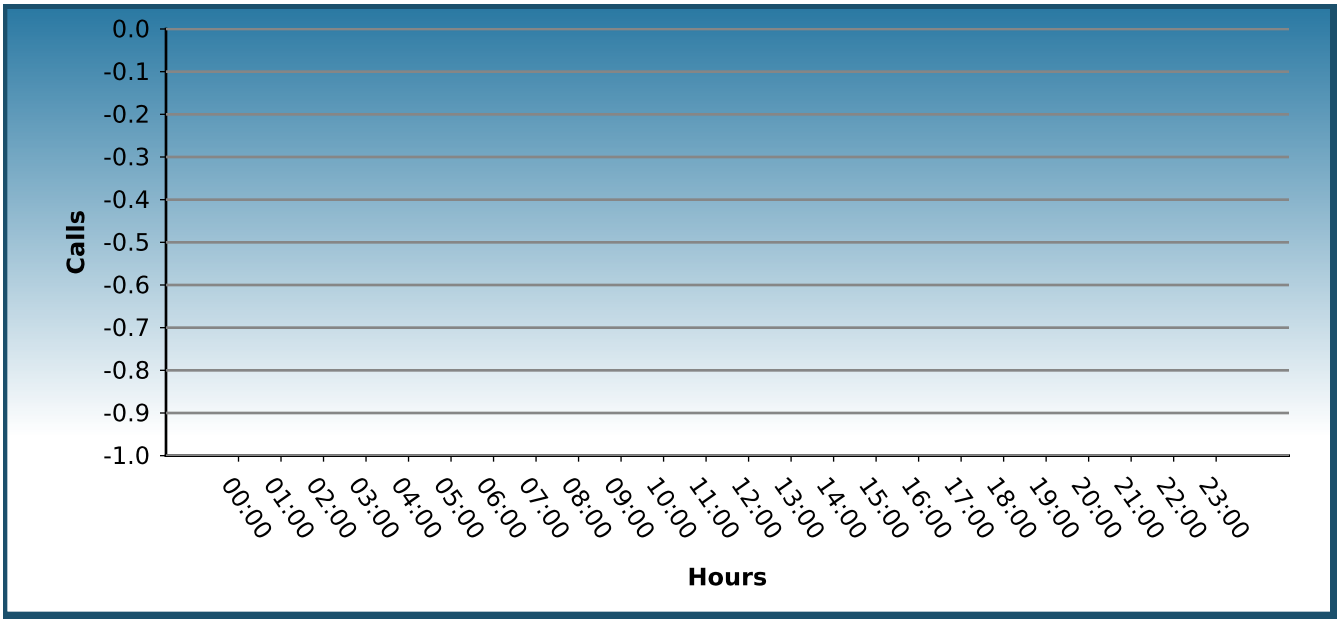
# Calls By Weekday

| 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**

# 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 |

# URBAN TRANSMISSION REPORTS

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

Today's Date: 05/28/2026 | Data As Of: 05/17/2026

INDIAN HEALTH SERVICE

# Urban AREA Data Loaded to the NDW

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

Today's Date: 05/28/2026 | Data As Of: 05/17/2026

## 87: NAVAJO URBAN

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 | 5 |

# URBAN 1ALOE MONTHLY REPORT

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

Today's Date: 05/28/2026 | Data As Of: 05/17/2026

INDIAN HEALTH SERVICE

# Report 1A - **URBAN** By Location of Encounter
# Ambulatory Care Visits by Provider and Month of Service

Report Date: 10/01/2025 thru 09/30/2026
Today's Date: 05/28/2026
Data As Of: 05/17/2026

AREA: 87

Service Unit: 8787

Facility: 878711: OUTPATIENT VISIT & PRIMARY CARE VISIT TOTALS

| Visit Type | Year to Date | % of Total |
|---|---|---|
| TOTAL OUTPATIENT VISITS | 4,302 | 100.0 |
| TOTAL PRIMARY CARE VISITS | 3,187 | 74.1 |

| Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 628 | 635 | 715 | 587 | 601 | 730 | 406 | 0 | 0 | 0 | 0 | 0 |
| 451 | 455 | 573 | 423 | 432 | 507 | 346 | 0 | 0 | 0 | 0 | 0 |

***** : Asterisk (*) indicates primary care patient visit.

| Code | Primary Provider of Service | Year to Date | % of Total | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| C9 | *BEHAVIORAL HEALTH AIDE/PRACTITIONER | 1,442 | 33.5 | 239 | 203 | 242 | 196 | 183 | 217 | 162 | 0 | 0 | 0 | 0 | 0 |
| D1 | *BEHAVIORAL HEALTH NURSE PRACTITIONER | 300 | 7.0 | 46 | 44 | 58 | 33 | 36 | 58 | 25 | 0 | 0 | 0 | 0 | 0 |
| 00 | *MD | 379 | 8.8 | 61 | 80 | 106 | 31 | 28 | 45 | 28 | 0 | 0 | 0 | 0 | 0 |
| 21 | *NURSE PRACTITIONER | 1,052 | 24.5 | 96 | 128 | 167 | 160 | 184 | 186 | 131 | 0 | 0 | 0 | 0 | 0 |
| 29 | DIETITIAN | 73 | 1.7 | -- | -- | -- | -- | -- | -- | -- | 0 | 0 | 0 | 0 | 0 |
| 45 | *OSTEOPATHIC MEDICINE | -- | 0.3 | -- | 0 | 0 | -- | -- | -- | 0 | 0 | 0 | 0 | 0 | 0 |
| 48 | ALCOHOLISM/SUB ABUSE COUNSELOR | 756 | 17.6 | 129 | 141 | 89 | 100 | 115 | 151 | 31 | 0 | 0 | 0 | 0 | 0 |
| 92 | PSYCHOTHERAPIST | 286 | 6.6 | 41 | 31 | 44 | 49 | 41 | 57 | 23 | 0 | 0 | 0 | 0 | 0 |

**- -** : Double hyphen indicates redacted data. 0: Zero indicates no data was reported in that time frame.

**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.

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 – June 2026**

# Major Highlights

**NextGen Patch Issue - Update**

- Patch 308 was completed in Prod 5/7/2026
- Post update Billing discovered an issue when trying to billing encounters
- Critical Case was submitted and escalated multiple times
- With assistance from NG Account Management we were able to get higher level support to help troubleshoot.
- It was discovered that a there was a duplicate Place Of Service line in one of the Master Files which was causing a conflict / error to occur when trying to bill out charges where said POS was attached.
- I updated the table manually in SQL, removing the duplicate entry which resolved the error

**Luma Project**

- Go-Live 5/12/2026
- Continuing to identify workflow adjustments
- Eligibility Configuration has begun
- Ipads have been purchased to utilize Tablet Intake App Dashboard
    - Currently being configured by TeamLogicIT

**Dymo Labeler**

- Cassie is working on configuring the labeler for network printing so that it can be shared for all MA's to be able to print lab specimen labels to

# Major Challenges

**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
- GPRA 2026 update are now available

NACA
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**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
- Ipad configuration for Tablet Intake App Dashboard

**NextGen 8 Upgrade**

- Waiting on confirmation of next cohort upgrade around August/September

**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

**Signature Pads**

- Looking into identifying what is need to get signature pads installed

**Health Promotion & Wellness Center Program**

**June 2026 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.
- Native Food For Life is completed.
- The garden blessing was held on May 30th. The event had a good turnout with a cultural storyteller/speaker in attendance.

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.
- 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 finished its first cohort.
- The second half of 2026's funding notice of award has been received. Full funding for SDPI has been received.

4 in 1 Grant

- Pathways completed the school year. Staff will transition over to assisting with summer programming.
- Community Cooking class – NACA HP is 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. There have been 2 sessions held so far.
- The grant's continuing application was awarded for the next grant year.

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.

**Behavioral Health**

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

Mental Health Contacts: Sep 599, Oct 632, Nov 486, Dec 511, Jan 566, Feb 524, Mar 612, Apr 642, May 595
Substance Abuse Contacts: Sep 251, Oct 336, Nov 262, Dec 232, Jan 249, Feb 243, Mar 312, Apr 330, May 236
New Intakes: Sep 36, Oct 56, Nov 49, Dec 40, Jan 55, Feb 53, Mar 77, Apr 77, May 53
Total Encounters: Sep 886, Oct 1024, Nov 797, Dec 783, Jan 870, Feb 820, Mar 1,001, Apr 1049, May 884

Major Highlights:

May was quite a busy month for the BH department. We hosted two events during the month. We provided the Cedar Room for 4 hours to the NAU MSW Leadership retreat. We also hosted a Play therapy conference for 4 hours in the Hopi conference room, 3 of my therapists attended.

I attended two quarterly meetings this month. The CIP Workgroup met to discuss issues surrounding Children of Incarcerated Parents, where our own Juliette Roddy was the lead speaker for the meeting. I also attended the Coconino County Crisis System meeting to give NACA representation at this meeting.

We hosted a well-attended and moving gathering for MMIWP this year. We had collateral-victims present to all those attending. We had 4 of them tell their stories to the gathering. The drum group was outstanding and healing. We also had 25 students from Summit High School in attendance.

We kicked off Luma this month and started our training on the Relias platform.

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