River Valley
Health & Dental
Your Center for Care

471 Hepburn Street
(Hepburn Plaza)
Williamsport, PA 17701

Policies for Review for September 2022

Dental Policies
Radiology Safety Manual: New
Dental Radiograph Standing Order: New

Clinical Policies
10.0.01 Health Literacy: Title change for policy owner. No other changes recommended.
10.0.02 Abnormal Test Results: Title change for policy owner. No other changes recommended.
10.0.03 Activation of Advanced Directives: Title change for policy owner. No other changes recommended.
10.0.04 Behavioral Health Manual: Page 1: Definition of a BHC—removed licenses social worker as position needs to be a licensed CLINICAL social worker or Licensed Professional Counselor. Page 1: Removed that BHC can be a graduate student, effectively without a masters or license. The Center can not bill for those services or incident to. Page 11: Eliminated barriers to patients seeing BHC. Removed necessity of a referral to BHC from the PCP and kept "the patient can request to meet with the BHC either face to face or in person. Page 12: Documentation: changed "SOAP note" to "Visit Note" as SOAP format is not being utilized. Removed Axis I-V diagnoses as they are not utilized.
10.0.05 Childhood Immunizations: Title change for policy owner. No other changes recommended.
10.0.06 After Hours Management of Critical Lab Results and Life Sustaining Med Refill Request: Title change for policy owner. No other changes recommended.
10.0.07 Unassigned Policy Number
10.0.08 Controlled Substance: Title change for policy owner. No other changes recommended.
10.0.08 Attachment A: No changes.
10.0.09 Photos for Clinical Purposes: Title change for policy owner. No other changes recommended.
10.0.10 Nitrous Oxide Administration: Title change for policy owner. It is being recommended this policy be moved to a new chapter titled "Dental" Chapter number will be "9" Policy number will be 9.0.01 if approved.
10.0.11 Dental Patients: Title change for policy owner. It is being recommended that this policy be moved to a new chapter titled "Dental" Chapter number will be "9" Policy number will be 9.0.02 if approved.
10.0.12 Dental Radiographs: Title change for policy owner. It is being recommended that this policy be moved to a new chapter titled "Dental" Chapter number will be "9" Policy number will be 9.0.03 if approved. Also added to the procedure to refer to dental radiograph standing orders for American Dental Association guidelines.

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10.0.13 Hygiene Standing Order: This policy is on hold for further review.
10.0.14 Unassigned Policy Number
10.0.53 Telepsychiatry: Change in attendance policy for new evaluations. The reason for the change is to minimize the high rate of no-show visits for new evaluations and to be sure that patients enrolled in telepsychiatry are active in their enrollment in primary care with the center.

Patient Flow
12.0.01 Appointment Policy and Procedure: Policy owner changed to Front Office Manager. New patient process changed. Addition: No more than two siblings can be scheduled consecutively per provider.
12.0.05 New Patient Registration Guidelines: Policy owner changed to Front Office Manager. New patient process changed. Addition: Clinical staff will notify front staff three days prior to any appointment that does not have records—high priority—follow up.

Next Month:
Clinical Policies
10.0.13 and 10.0.15 – 10.0.29

Quality Management
15.0.05 Corporate Compliance Plan

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Radiology Safety Manual

Policy Category: Dental Policies
Policy Owner: Director of Clinical Operations
Origination Date:
First Date Approved by Board of Directors:

Purpose: Susquehanna Community Health and Dental Inc (SCH&DC) is committed to the program described herein for keeping individual and collective doses as low as is reasonably achievable (ALARA). In accord with this commitment, we hereby describe an administrative organization for radiation safety and will develop the necessary written policy, procedures, and instructions to foster the ALARA concept within our institution.

Policy: We will perform a formal annual review of the radiation safety program, including ALARA considerations.

ROUTINE RADIOGRAPHIC EXAMINATIONS

- 4 BWX- Adult)- Four routine bitewing xrays
- 2 BWX- Two routine bitewing x-rays
- PAN- Routine panoramic x-ray

NON-ROUTINE X-RAYS

- All routine and non-routine x-ray examinations must include written orders prior to the examination being performed by a Dental Assistant or Expanded Function Dental Assistant (EFDA).
- A Public Health Dental Hygiene Practitioner (PHDHP) may determine need for x-rays without a dentist order.
- Standing order for patients is allowed in the practice of dentistry when the following requirements are met:
    a. The standing orders are in writing (see Dental Radiograph Standing Orders Policy)
    b. Signed by all the dentists
    c. The facility establishes a policy that defines the scope of the recall patient standing order.

LEAD PROTECTIVE DEVICE USE

- Lead protective aprons and thyroid collars for patient protection is not required in the practice of dentistry.
- A lead protective apron is required only when the primary x-ray beam is within 2 inches of the gonads.
- Individuals other than the patient who must remain in the operatory, and are within six (6) feet of the patient or the x-ray tube must wear a lead protective apron of at minimum 0.5 mm lead equivalency.

- We recognize the genetically significant dose from dental radiography is small, however because of the public's expectation of the issue, we will use a lead apron whenever feasible.

USE OF IMAGE RECEPTOR HOLDERS

- Image receptor holders, i.e. extension cone paralleling (XCP) or Rinn devices, etc should be used whenever possible, when the quality of the image is not affected by the holder or the holding method.
- Direct holding of the x-ray film or recording device by dental personnel is prohibited.
- If dental personnel need to help a patient hold a film or recording device, they can only do so by using a device that assures they will not be exposed by the primary xray beam.
- Patients are allowed to hold the image receptor when the use of image receptor holders is not feasible, as in the case of endodontic procedures.
- Dental x-ray equipment has a defined x-ray field that limits the radiation exposure to the patient's area of interest. When the image receptor, image receptor holder and x-ray equipment are used properly it can significantly reduce unnecessary radiation exposure to the patient.
- Place the cone of the x-ray tube as close to the patient's skin as possible to reduce potential exposure to the thyroid, eyes and other radiosensitive areas.
- Follow image receptor holders and alignment tool procedures for use.

USE OF MOBILE OR PORTABLE MACHINES

- When hand-held intraoral units are used, the backscatter shield must be in place as close to the patient as possible.
- Approved battery-powered dental x-ray devices are exempt from the 2-meter safety distance rule and from wearing the lead apron requirement when manufacturer specifications are followed, i.e., use of the back scatter shield.
- The x-ray machine operator must be positioned so that his/her exposure to scatter radiation is as low as reasonably achievable (ALARA). *The operator shall remain 2 meters (6.5 feet) or more away from the tube and patient unless behind a barrier. The operator should never be in line with the direct beam.
- If the x-ray machine operator must be closer than 2 meters (6.5 feet) from the patient or tube, the operator must wear a lead apron.
- No person may hold the x-ray tube housing during the exposure. A stand or other means of support shall be used during the exposure. There is the possibility of electric shock from improper grounding if the machine is held.

Signatures:

Dental Director _____ Date_____

Director of Clinical Operations _____ Date_____

Board Chair _____ Date_____

CEO _____ Date_____

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Dental Radiograph Standing Orders

Policy Category: Dental Policies
Policy Owner: Director of Clinical Operations
Origination Date: 8/19/2022

Purpose: Susquehanna Community Health and Dental Inc (SCH&DC) is committed to the program described herein for keeping individual and collective doses as low as is reasonably achievable (ALARA). In accord with this commitment, we hereby describe the standing orders for x-rays that may be taken following American Dental Association (ADA) criteria.

Policy:

1. All routine and non-routine x-ray examinations must include written orders prior to the examination being performed by a Dental Assistant or Expanded Function Dental Assistant (EFDA).
2. A Public Health Dental Hygiene Practitioner (PHDHP) may determine need for x-rays without a dentist order.
3. Standing order for patients is allowed in the practice of dentistry when the following requirements are met:
    a. The standing orders are in writing
    b. The facility establishes a policy that defines the scope of the recall patient standing order.
4. Refer to Dental Radiograph Standing Order Procedure

Signatures:

Dr. Dan Bozza _____ Date_____

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Dental Radiograph Standing Orders Procedure

Policy Category: Dental Procedure
Policy Owner: Director of Clinical Operations
Origination Date: 8/19/2022

Purpose: Susquehanna Community Health and Dental Inc (SCH&DC) is committed to the program described herein for keeping individual and collective doses as low as is reasonably achievable (ALARA). In accord with this commitment, we hereby describe the standing orders for x-rays that may be taken following American Dental Association (ADA) criteria.

Procedure:

1. All routine and non-routine x-ray examinations must include written orders prior to the examination being performed by a Dental Assistant or Expanded Function Dental Assistant (EFDA).
2. A Public Health Dental Hygiene Practitioner (PHDHP) may determine need for x-rays without a dentist order.
3. SCH&DC will follow the American Dental Association guidelines for radiology exams.

Guidelines:

<table>
<tr><th rowspan="2">TYPE OF ENCOUNTER</th><th colspan="5">PATIENT AGE AND DENTAL DEVELOPMENTAL STAGE</th></tr>
<tr><th>Child with Primary Dentition (prior to eruption of first permanent tooth)</th><th>Child with Transitional Dentition (after eruption of first permanent tooth)</th><th>Adolescent with Permanent Dentition (prior to eruption of third molars)</th><th>Adult, Dentate or Partially Edentulous</th><th>Adult, Edentulous</th></tr>
<tr><td>New Patient* being evaluated for oral diseases</td><td>Individualized radiographic exam consisting of selected periapical/occlusal views and/or posterior bitewings if proximal surfaces cannot be visualized or probed. Patients without evidence of disease and with open proximal contacts may not require a radiographic exam at this time.</td><td>Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.</td><td colspan="2">Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized oral disease or a history of extensive dental treatment.</td><td>Individualized radiographic exam, based on clinical signs and symptoms.</td></tr>
<tr><td>Recall Patient* with clinical caries or at increased risk for caries**</td><td colspan="3">Posterior bitewing exam at 6-12 month intervals if proximal surfaces cannot be examined visually or with a probe</td><td>Posterior bitewing exam at 6-18 month intervals</td><td>Not applicable</td></tr>
<tr><td>Recall Patient* with no clinical caries and not at increased risk for caries**</td><td colspan="2">Posterior bitewing exam at 12-24 month intervals if proximal surfaces cannot be examined visually or with a probe</td><td>Posterior bitewing exam at 18-36 month intervals</td><td>Posterior bitewing exam at 24-36 month intervals</td><td>Not applicable</td></tr>
</table>

TYPE OF ENCOUNTER (continued)	**Child with Primary Dentition** (prior to eruption of first permanent tooth)	**Child with Transitional Dentition** (after eruption of first permanent tooth)	**Adolescent with Permanent Dentition** (prior to eruption of third molars)	**Adult, Dentate and Partially Edentulous**	**Adult, Edentulous**
Recall Patient* with periodontal disease	Clinical judgment as to the need for and type of radiographic images for the evaluation of periodontal disease. Imaging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be demonstrated clinically.				Not applicable
Patient (New and Recall) for monitoring of dentofacial growth and development, and/or assessment of dental/skeletal relationships	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development or assessment of dental and skeletal relationships		Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development, or assessment of dental and skeletal relationships. Panoramic or periapical exam to assess developing third molars	Usually not indicated for monitoring of growth and development. Clinical judgment as to the need for and type of radiographic image for evaluation of dental and skeletal relationships.	
Patient with other circumstances including, but not limited to, proposed or existing implants, other dental and craniofacial pathoses, restorative/endodontic needs, treated periodontal disease and caries remineralization	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of these conditions				

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Nitrous Oxide Administration

Policy Category: 9.0.01 Dental~~10.0.10 Clinical~~
Policy Owner: Director of Clinical Operations~~Dental Director~~
Origination Date: 05/11/2022
First Date Approved by Board of Directors: 05/24/2022

Purpose:

Nitrous oxide will be used in RVHDC Dental Offices under the direction of a licensed dentist when clinically indicated and appropriate for effective patient care. Quality will be assured by annual competencies.

Policy:

Nitrous Oxide-Oxygen will only be used as an anxiolytic adjunct when treating children generally between the ages 3-8 and adult patients when indicated.

Prior to the use of nitrous oxide, the licensed dentist will review the risk vs. benefit to the patient, or patient's parent or legal guardian as well as the patient's overall medical history.

Verbal and written consent will be obtained from the patient, or patient's parent or legal guardian prior to the administration of the nitrous oxide. A "time out" is also completed prior to administration. Consent and time out is documented in the clinical notes.

REVIEWED: 08/26/2022

REVISED:

Signatures:

_____ _____ Date:
Kimberly Wetherhold, Board Chair James Yoxtheimer, President & CEO

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Dental Patients

Policy Category: 9.0.02 Dental~~10.0.11 Clinical~~
Policy Owner: Director of Clinical Operations~~Dental Operations Manager~~
Origination Date: 10/18/2012
First Date Approved by Board of Directors: 10/22/2012

Policy:
All patients receiving dental services through the Susquehanna Community Health & Dental Clinic, Inc. (SCH&DC) will be provided with a referral to primary care and other dental offices if all dental needs cannot be met within our facility.

Purpose:
To provide complete and adequate health and dental care to all patients of record.

Procedure:
1. All patients will receive a comprehensive or periodic evaluation as indicated by their dental provider.
2. Unmet or pre-existing medical concerns will be referred for primary care. Documentation will be required in the dental chart under Medical Consult.
3. Dental needs that cannot be treated at the SCH&DC will be referred to a provider who can complete the needed treatment. Documentation will be required in the dental chart.
4. Patients treated by the clinical dental hygienist will have their x-rays read by a dentist. Should the dentist not be present, the patient will be scheduled for an exam. Documentation will be required in the dental chart.

REVIEWED: 01/20/2014, 04/08/2016, 09/01/2018, 09/02/2019, 09/01/2020, 09/03/2021, 08/26/2022

REVISED: 01/20/2014, 09/24/2018, 09/23/2019

Signatures:

_____ _____ Date:
Kimberly Wetherhold~~John Boll, Jr. D.O.~~, Board Chair James Yoxtheimer, President & CEO

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Dental Radiographs

Policy Category: 9.0.03 Dental~~10.0.12 Clinical~~
Policy Owner: Director of Clinical Operations~~Dental Operations Manager~~
Origination Date: 10/18/2012
First Date Approved by Board of Directors: 10/22/2012

Purpose:
To aid staff in choosing consistent and appropriate selection of dental radiographs for each dental patient.

Policy:
1. Comprehensive exam patients will receive a panoramic radiograph and bitewing radiographs. Periapical radiographs will be taken of specific complaint areas.
2. Periodic recall patients will receive bitewing radiographs after one-year, panoramic radiograph after five years, and periapical radiographs of specific complaint area as needed. Periodic recall patients may receive bitewings x-rays more than once a year, if recommended by the dentist.

Procedure:
1. Dental assistant or dental hygienist will assess what radiographs are due to be taken within the above time limits. Only the dentist may change the order.
2. Patients will be informed of needed radiographs, if patient refuses radiographs, the dentist will be notified.
3. The dentist will discuss refusal of radiographs with the patient and the outcome will be noted in the dental chart.
4. The dentist has the right to refuse treatment if radiographs are required to perform that treatment.
~~4.~~5. Refer to dental radiograph standing orders for American Dental Association (ADA) guidelines.

REVIEWED: 01/10/2014, 04/08/2016, 09/01/2018, 09/02/2019, 09/01/2020, 09/03/2021, 08/26/2022

REVISED: 01/20/2014, 09/24/2018, 09/23/2019

Signatures:

_____ _____ Date:
Kimberly Wetherhold~~John Boll, Jr. D.O.~~, Board Chair James Yoxtheimer, President & CEO

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Health Literacy Policy

Policy Category: **10.0.01 Clinical**
Policy Owner: **Director of Clinical Operations~~Clinical Operations Manager~~**
Origination Date: **11/1/2018**
First Date Approved by Board of Directors: **11/26/2018**

Policy:
It is the policy of Susquehanna Community Health and Dental Clinic, Inc. (SCH&DC) to support and empower our consumers to make effective decisions and take appropriate action for their health and health-care

Purpose:
This policy describes the process for ensuring that healthcare providers at SCH&DC communicate effectively and can properly evaluate a consumer's understanding of information that is communicated to them.

Process:
All SCH&DC staff will receive periodic health literacy training so that staff can have the tools to provide information that is easily understood by SCH&DC consumers.

All spoken and written communication targeting consumers will be easily understood and tailored to the needs of people from a diverse range of backgrounds.

SCH&DC shall perform regular assessments of health education materials and communications of services and environment.

SCH&DC consumers requiring additional support to make effective decisions and ensure understanding of health information will be referred to the Community Navigator or Health Educator.

Community Navigators/Health Educators will assist patients in understanding health information including but not limited to health promotion materials, forms, and plans of care.

REVIEWED: 08/28/2019, 09/01/2020, 09/02/2021, 08/26/2022

REVISED: 09/23/2019, 09/28/2021

Signatures:

_____ _____ Date:

Kimberly Wetherhold, Board Chair James Yoxtheimer, President & CEO

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Abnormal Test Results

Policy Category: **10.0.02 Clinical**
Policy Owner: **Director of Clinical Operations~~Clinical Operations Manager~~**
Origination Date: **08/27/2012**
First Date Approved by Board of Directors: **08/27/2012**

Policy:
The provider will review all diagnostic results.

Purpose:
To ensure all clinical test results are reviewed and managed by a health care provider. A health care provider will manage all abnormal test results.

Process:
1. All abnormal results are returned in red bringing them to the provider's attention.
2. Abnormal test results are reviewed by the ordering provider or covering provider and signed off in the electronic health record (EHR).
3. Attempts to notify the patient are documented in the EHR.
4. The nurse assigned to that provider is responsible for all orders in their nurse box.
5. A nurse will communicate the provider's care plan to the patient. This will be documented in the EHR.
6. Patients are notified by mail if unable to be contacted by telephone within 48 hours.
7. Results of tests not ordered by SCH&DC providers are informational only and will not include clinical guidance unless the patient is at risk of significant morbidity or mortality
8. If a test requires emergent intervention, the patient is notified immediately. If unable to reach the patient the nurse will notify the emergency contact. If still unable to reach the patient, the nurse will notify the provider and may obtain an order to send the community navigator or dispatch the police. Nursing will document in the EHR.

REVIEWED: 10/18/2012, 01/10/2014, 04/08/2016, 04/21/2017, 09/01/2018, 09/02/2019, 09/01/2020, 09/02/2021, 08/26/2022

REVISED: 10/22/2012, 01/20/2014, 09/24/2018, 10/28/2019, 09/28/2021

Signatures:

_____ _____ Date:
Kimberly Wetherhold, Board Chair James Yoxtheimer, President & CEO

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Activation of Advanced Directives Policy

Policy Category: **10.0.03 Clinical**
Policy Owner: **Director of Clinical Operations~~Clinical Operations Manager~~**
Origination Date: **08/27/2012**
First Date Approved by Board of Directors: **08/27/2012**

Policy:
Susquehanna Community Health & Dental Clinic, Inc. (SCH&DC) will honor all valid advance directives of patients regarding their care and treatment. Advance Directive forms that are filled out by patients will be reviewed with the patient by SCH&DC providers to ensure that the patient understands the associated effects of carrying out those directives.

REVIEWED: 01/10/2014, 09/01/2018, 09/02/2019, 09/01/2020, 08/26/2022

REVISED: 01/20/2014, 04/08/2016, 04/14/2017, 09/24/2018, 09/23/2019, 09/28/2021

Signatures:

_____ _____ Date:
Kimberly Wetherhold, Board Chair James Yoxtheimer, President & CEO

River Valley Health & Dental Clinic

Behavioral Health Consultation In Primary Care

Practice Manual

Reviewed/Revised: 04/08/2016, 12/14/2017, 09/01/2020, 09/02/2021

Approved by Board of Directors: 03/17/2014, 03/16/2015, 12/18/2017, 09/28/2020

PROGRAM PRINCIPLES, DEFINITIONS, AND GOALS

The primary goal in developing the Behavioral Health Consultant (BHC) service is to allow for integration of behavioral health providers into the primary and dental care service. Establishing the behavioral health consultant service achieves the goal of behavioral health and primary care integration through utilization of a consultative model. A ***consultative model*** implies that the behavioral health provider is a consultant to the primary care provider(s) (who retain primary responsibility for patient care) and as such does not function as a specialty mental health provider. It is expected that integrating behavioral health consultants into the primary care service will yield the following results:

- Improved recognition of behavioral health needs within the primary care service;
- Improved collaborative care and management of patients with psychosocial issues in primary care;
- Creation of an internal resource for primary care providers to assist in addressing patients' psychosocial concerns or behavioral health issues, thereby reducing the need for referrals to the specialty behavioral health service;
- Improved patient access to behavioral health services through rapid access to Behavioral Health Consultants and rapid feedback from BHCs to providers;
- Improved fit between the behavioral healthcare patients seek in primary care and the behavioral health services offered;
- Prevention of more serious mental health disorders through early recognition and intervention;
- Triage into more intensive specialty behavioral health care by the Behavioral Health Consultant;
- And, provision of behavioral health care services to a larger proportion of the population in need of those services than that which could be provided by the co-located specialty behavioral health care service.

Adopting a behavioral health consultative model requires a shift in paradigm from that of the specialty behavioral health care model. Table 1 compares distinguishing characteristics of the consultative and specialty behavioral health care models.

Table 1: Conceptual Distinctions Between Consultative Versus Specialty Behavioral Health Care

Dimension	Consultative Behavioral Health Care	Specialty Behavioral Health Care
Model of care	Population-based	Patient-based
Primary customers	First – providers; Second – Patients	First - Patient; Second – Others
Primary goals	• Promote provider effectiveness • Improve behavioral health of population • Support small patient-change efforts • Prevent morbidity in high-risk patients • Achieve medical cost offset	Resolve patient's mental health issues
Service delivery structure	Part of primary care service	A specialized service, located in or outside of primary care service
Who is "in charge" of patient care	Provider	Therapist
Primary modality	Consultation model	Specialty treatment model
Team structure	Part of primary care team	Part of specialty mental health team
Access standard	Determined by provider preference	Determined by patient preference
Cost per episode of care	Potentially decreased	Highly variable, related to patient condition

About This Manual

This manual introduces the roles and responsibilities of the **Behavioral Health Consultant (BHC).** The BHC is a mental health provider who (1) operates in a consultative role within the primary care service and (2) offers recommendations for and delivery of behavioral interventions. Behavioral health consultants will be Licensed Clinical Social Workers ~~either licensed social workers, counselors,~~ psychologists or Licensed Professional Counselors. ~~They may also be second year graduate students studying in an approved program and eligible to be reimbursed by our payors~~. Within the consultative model, psychiatrists will serve a consultation/liaison role.

Key Principles of the Behavioral Health Consultation Services

Principle #1. The BHC's role is to identify, target treatment, triage, and manage primary care patients with medical and/or behavioral health problems.

The clinical model to be utilized within the consultative framework will be the behavioral health approach. The defining characteristics of this approach to care are that:

- Maladaptive behaviors are learned and maintained by various external or internal rewards;
- Many maladaptive behaviors result from skill deficits; and
- Direct behavior change is the most powerful form of human learning.

Consequently, consultative interventions focus upon:

- Helping patients to replace maladaptive behaviors with adaptive behaviors;
- Providing skill training through psycho-education and patient education strategies; and
- Developing specific behavioral change plans that fit the fast work pace of the primary care service.

While these plans may be developed in collaboration with the patient, they are designed to be implemented via the provider-patient dyad, with the BHC providing minimal back-up support.

<u>Principle #2.</u> The BHC program is grounded in a population-based care philosophy that is consistent with the mission and goals of the primary care model of care.

The population-based care perspective provides a flexible and powerful framework for behavioral health program development. Population-based care is built on a public-health view of service-delivery planning. In this perspective, the service "mission" is not just to address the needs of the "sick" patient, but to think about similar patients in the population who may be at-risk, or are sick but do not seek care. Additionally, a population-based care approach provides a specific template for addressing local facility service needs. As such, it is important to customize behavioral health consultation services to address local population needs and characteristics. A few examples of typical population-based service planning questions will illustrate this point: What percentage of the population has conditions like this? How many seek care? Where do they seek care? Are there variations in the way care is being provided for patients like this that result in differential clinical outcomes? Can we prevent the condition from occurring in patients who have similar risk factors?

At the level of behavioral health consultation services, the same approach can be used to customize services to address the needs of particular patient populations. For example, what types of behavioral medicine service needs exist in the population of patients serviced by the specific primary care service team? What type of service delivery structure will allow for maximum penetration into the whole population? What types of interventions will work with the "common causes" of psychological distress? What secondary, and more elaborate, interventions are appropriate for the primary care setting? At what level of complexity is a patient better treated within the specialty behavioral health care service? These are pivotal service-delivery planning questions, which can influence behavioral health program planning at the local level.

The following two complementary frameworks address how the behavioral health needs of the primary care population will be met through utilization of behavioral health consultation services.

General Consultation Framework (Horizontal Integration)

This is the platform upon which all BHC services reside because most members of the primary care population can benefit from BHC services delivered in a general service-delivery model. A distinguishing feature of general consultation (horizontal integration) is that it "casts a wide net" for eligibility. From a population-based care perspective, the goal is to enroll as many patients as possible into brief, general, psychosocial services. Traditional primary care medicine is based largely upon this type of approach. The goal is to 'tend the flock" by providing a large volume of general healthcare services, none of which is highly specialized. Providers usually refer patients who truly require specialized expertise to medical specialists. Similarly, we can expose patients with behavioral health needs to non-specialized services, while referring those that truly require specialty care to the specialty behavioral health service.

Population-Based Integrated Care Framework (Vertical Integration)

This framework involves providing targeted, more specialized, behavioral health services to a well-defined, circumscribed group of primary care patients, such as those with major depression. This is a major contemporary development in primary care medicine (i.e., use of a "critical pathway," "clinical roadmap," or "best practices" approach). Targets for this type of approach are usually patient populations with high frequency and/or high cost

conditions, such as depression or anxiety disorders, as well as certain groups of high medical utilizers. With respect to frequency, a complaint that patients present frequently in the population (like depression) is a good indication of a group of patients that require a special process of care. With respect to cost, some rare conditions are so expensive that they require a special system of care (for example, patients with chronic and several behavioral health problems). In the behavioral medicine arena, high utilizers of medical care, by definition, compose a small but costly group that often are the targets of integrated care programs. There also exist a variety of patient populations within a typical primary care setting that can be served effectively through psychoeducational group programs. Such programs might focus upon hypertension education, bereavement issues, diabetes education, etc.

***Principle #3* Provider team members are primary customers.**

The BHC's role is to support ongoing behavioral health interventions provided by the providers or dentists. There is no attempt to "take charge" of a patient's care, as is the case when a patient is referred to the specialty behavioral health service. The focus is on resolving problems within the primary care service context. In this sense, the BHC is a key member of the provider team, functioning like a consultative medical specialist. Accordingly, the BHC provides all services within a collaborative framework. The BHC visits are brief (15 to 30 minutes), and are provided within the primary care service practice area. The referring provider is the chief "customer" of the BHC service and, at all times, remains in charge of the patient's care.

***Principle #4.* The BHC promotes a smooth interface between primary care, specialty mental health care, psychiatry, and other behavioral health services.**

The BHC promotes effective liaison between primary care and a variety of behavioral health services. Conceptually, the underpinning philosophy is that an effective, full continuum of behavioral services is necessary in order to match a patient's potential level of need with the appropriate level of care. A major system goal is to use effective triage practices to determine which patients the BHC can manage best within primary care, and which patients require referral for specialty behavioral health care. This is a bi-directional conduit meaning that the BHC facilitates referrals into specialty behavioral health care services, while also being a liaison as cases are transferred back to primary care providers for ongoing maintenance care. Table 2 compares defining characteristics of the consultative and specialty behavioral health treatment models.

Program Goals

Program Goals	Service Delivery Features
Improve clinical outcomes for acute /chronic conditions through assessment, treatment, follow-up monitoring and/or appropriate triage.	Use collaborative care intervention model; implement best practice guidelines for high frequency conditions such as depression; build on existing PC interventions/suggest new ones; use motivational interviewing techniques to increase patient adherence, coordinate acute care management with primary care team.
Use prevention and wellness strategies to prevent the onset of a mental health disorder or prevent its recurrence.	Open door service philosophy to encourage referrals from providers for patients going through life stresses/transitions/new diagnosis; monitor "at risk" situations.
Provide consultation and education for PC and dental team in use of appropriate psychosocial treatments and medications.	Employ collaborative treatment model emphasizing co-management of patient care; offer basic collaborative visits to address care management issues; develop/model interventions that are tailored to the "15-30 minute contact."
Manage high utilizing patients with chronic health and behavioral health concerns to reduce inappropriate medical utilization and to promote better functional outcomes.	Long term care management follow-up reserved for patients identified by providers as complex or chronic and with numerous medical and/or psychosocial concerns. BHC will provide brief therapy, support or psychoeducation classes to promote better self management within the collaborative framework. BHC will also work with PC team members to identify and manage psychiatric symptoms arising from physical disease.
Accurately identify and place patients requiring specialized behavioral health treatment.	Develop and employ referral criteria to triage patients to specialty care; function as a liaison between specialty system and PC team. When possible, preference given to behavioral health specialists with similar values.

CATEGORIES OF BEHAVIORAL HEALTH CONSULTATION SERVICES

Within the spectrum of behavioral health services, behavioral health consultation services include two basic approaches to service delivery:

General Behavioral Health Consultation Services within Primary Care and Dentistry

These comprise the majority of services provided by BHCs within the primary care service. The BHC is available for consultation with ***any patient referred by a provider for any behavioral health reason***. Within this approach, the BHC functions as a member of the primary care team. Overall the primary objectives are:

- Assist the providers in recognizing, treating, and managing mental health disorders and psychosocial issues;
- Enhance the skills of the providers in addressing behavioral health issues;
- Provide specific, focused interventions for primary care and dentistry; and
- Provide follow-up and relapse-prevention plans.

General consultation may involve recommending appropriate behavioral treatment strategies and/or pharmacotherapy, and it is tailored to fit the fast-paced environment of primary care. General consultation services involve directly assisting the provider in treatment planning and monitoring, addressing community resource needs of patients (including referrals to specialty behavioral health care), and follow-up consultation services as part of either a chronic or acute care treatment plan.

There are two basic types of general consultation services: **brief general** and **consultative co-management/continuity/specialty.** **Brief general consultations** are time-limited and usually appropriate for primary care patients who are higher functioning. Brief consultations generally comprise one to three visits. The majority of consultations provided by BHC will fall into this category. **Consultative co-management/continuity/specialty consultations** are appropriate for primary care patients who require more assistance, but are best treated within primary care rather than being referred to the specialty behavioral health service. They are appropriate for patients with chronic medical and/or psychological conditions who require a longer-term, intermittent, consultative approach. Continuity consultations are also referred to as "specialty" consultations, because they generally have some specialized focus. While more visits may be involved, these visits remain short in duration (30 minutes or less) and occur at infrequent, intermittent intervals.

Clinical Practice Guidelines

These programs present a consistent, treatment-package approach to an identified patient population, usually those with ***a high prevalence*** within the primary care population. Examples include those with uncomplicated major depressive, dysthymic, and sub-threshold depressive symptoms. Other potential pathway programs might involve patients with anxiety disorders, somatization issues, chronic pain, HIV+ status, diabetes and other physical or mental health disorders.

CONSULTANT ROLES & SERVICES

The Behavioral Health Consultant (BHC)

The BHC is to provide support and assistance to all SCH&DC providers, and their patients, without engaging in any form of extended specialty mental health care. BHCs provide triage and consultation at a provider's request. The role of the BHC is designed to avoid the unnecessary referrals to specialty mental health care, in which a patient is referred for behavioral health service, but there is little to no communication among BH and PC providers. To avoid this type of poorly integrated patient care, BHCs must understand how the consultative and specialty approaches differ in their service goals and practice styles (refer to Table 2).

In general, the BHC does not provide extended behavioral health care to a patient. Some consultations are single-session visits and provide immediate feedback about psychological intervention strategies to the referring provider. Interventions tend to be simple and compatible with those one can provide in a 15-minute healthcare. It is also clear to the patient that the BHC is helping both the providers and patient come up with an effective and comprehensive healthcare plan. The consultant choreographs follow-up consultations to reinforce provider-generated interventions. The goal is to maximize what often is a very limited number of visits to either the BHC or the provider. In this way, the BHC can follow patients needing longer-term surveillance in a manner that is very consistent with the way providers manage their at-risk patients.

The provider remains responsible for choosing and monitoring the results of interventions and always coordinates care. In this regard, the primary care provider "owns" the cases. Communicating back to the provider is one of the highest priorities of the BHC. BHCs are expected to maintain accurate reporting through the EMR and verbal communication.

A final notable aspect of the consultant model is that it allows for *in vivo* training of providers, built around specific casework. With feedback regarding many patients sent to the BHC, providers will begin to notice recurring themes in their patient panels and gain first-hand experience using effective behavioral intervention and pharmacological strategies supported by the BHC. Eventually the providers integrate these skills, and begins to implement both psychological and pharmacological interventions more effectively.

Typical BHC Services in Primary Care

- *Triage/Liaison:* Initial screening visits of 15-30 minutes, designed to determine appropriate level of mental health care.

- *Behavioral health consultation:* Initial visits with patients referred for a general evaluation; focus on diagnostic and functional evaluation, treatment recommendations, and forming limited behavior-change goals; involves assessing patients at risk because of some life-stress event; may include identifying whether patient would benefit from existing community resources, educating about these, or referring to social worker.

- *Behavioral health follow-up:* Secondary visit(s) to support behavior-change plan or treatment started by the BHC or providers based on earlier consultation; may occur in tandem with a planned provider visit.

- *Adherence enhancement:* Visit designed to assist a patient adhere to interventions initiated by the provider; focus on education, addressing negative beliefs, or strategies for coping with medication side effects.

- *Relapse prevention:* Visit to maintain stable functioning in a patient who has responded to previous treatment; often spaced at long intervals.

- *Behavioral medicine:* Visit to assist in managing a chronic medical conditions, or to tolerate invasive or uncomfortable medical procedures; focus may be on lifestyle or health-risk factors among patients at risk (i.e., smoking cessation, weight loss, stress management, etc); may involve managing issues related to progressive illness, such as diabetes, COPD, etc.

- *Consultative co-management, continuity or specialty consultation:* Consultative service to patients requiring ongoing monitoring and follow-up; applicable to those with chronic stressors and deficits in coping or adaptive skills.

- *Psychoeducational class*: Brief, group-based intervention that replaces or supplements individual consultative treatment to promote education and building skills.

- *Conjoint consultation*: Visit with provider and patient to address an issue of concern to both; may involve a conflict between them.

- *Care management*: Designed to minimize extensive and uncoordinated delivery of medical and/or mental health services, usually for chronic psychological and medical problems; involves linking patient to a care-management plan that include multi-disciplinary involvement.

- *Provider consultation*: Face-to-face visit with providers to discuss patient care; often involves "curbside" consultation.

Excluded Services

The following services are not considered to be within the purview of the Behavioral Health Consultant or the Consultation/Liaison Psychiatrist:

- Social work services other than routine community resource referrals;
- Specialized case management services;
- Psychotherapy;
- Diagnostic procedures exceeding brief interventions or the scope of care of the consultant; and
- Long-term group therapy services (psychoeducation groups are appropriate).

When the BHC receives a request from a patient or provider for any excluded service, the BHC will refer the patient to a social services case manager who will assist the patient.

BHC PROCEDURES

Accessing Behavioral Health Consultation Services

There are several ways that patients will access BHC services:

- Provider will identify patients with behavioral health needs during triage when the PHQ-2 is administered or at another time and notify the BHC.
- BHC will review providers' schedules and identify patients seen previously or patients who would benefit from BHC services.
- On-demand verbal referral from provider, will result in warm handoff for assessment and brief intervention.
- Provider will send a message via EMR to the BHC requesting that he/she see a patient as soon as possible.
- Provider will ask clerical to message or call BHC to see a pt in the clinic.
    - Clerical will check schedules of BHCs to see which person is working with patients during that time.
    - Clerical will contact BHC by sending a message in EMR or phone contact.
    - If after reviewing schedule, clerical sees that no BHC is available, clerical will inform provider
- Provider will ask clerical to schedule the patient to see the BHC at a future date.

Prioritizing Patient Care

On occasions when the BHC is much in demand and cannot see everyone that the providers have identified, an effort will be made to make sure the most needy and vulnerable receive BHC services. BHC staff are committed to seeing the patients that the providers identify, but on days when this is not possible, we will prioritize as follows:

- Patients who do not have outside psychiatric care, and those for whom PCPs are prescribing psychopharmaceuticals.
- Patients in crisis.
- Patients with whom BHC has had former contact, especially patients who are actively participating in their behavioral treatment.

BHC will inform the provider or the hub clerical/medical assistant, should it be necessary to prioritize patients. Additionally, there may be days when despite best efforts a BHC is not available due to scheduling difficulties, sickness or conferences.
On days when there is no BHC available, but one is on site but working an administrative block, it is requested that PCPs respect the administrative time of the BHC. Clerical should be able to access the BHC schedule and let the provider know who is available to see patients.

In all cases, the BHC is to documentation in the EMR the same day patient is seen, preferably immediately following the session, placing the referring provider initials under the provider line so that a note goes to his/her dashboard and the provider can review the note. If the BHC is a student and/or not licensed, the supervisor's initials are also placed under the provider line. Often, the BHC and the provider will find it useful to discuss questions and projected outcomes before the BHC's initial consultation visit with the patient. When this is possible, it is more likely to generate outcomes consistent with the provider's goals.

The BHC will screen all provider referrals for behavioral health care, including provider-generated referrals for specialty health care. In other words, all provider-generated referrals for behavioral health care will be reviewed and triaged by the BHC. Having the BHC review all referrals and determine of the level of care should help ensure that patients being referred out of the primary care service are appropriate for specialty behavioral health care. This should also result in the BHC recapturing some patients who would be better served receiving behavioral healthcare within the primary care service.

The BHC may be asked to triage referrals to the specialty behavioral health service from sources other than primary care to determine appropriate level of care. In addition, the BHC may be referred clients who are on the waiting list for specialty behavioral health services for provision of interim care.

Patients who ask to see a counselor at SCH&DC will be instructed that traditional counseling is not available, and they will be directed to BHC either via phone or face to face for BHC to assess and develop a plan of care appropriate to the situation. ~~but if they wish to see a BHC, the referral must come from their provider. There are two ways for these patients to be seen. If the patient has not had a provider visit within the last 2 months, they can be encouraged to make an appointment with the provider on a day a BHC is available. Clerical should follow the same procedure of identifying the patient in the PCP schedule with the BHC code. If the patient has recently seen their provider, with the providers approval the patient can be scheduled to see a BHC in one of the special slots reserved for appointments without a provider visit slots. (these are yellow on the BHC schedule)~~.

Indications for Specialty Behavioral Health Care

The main goal of the BHC's initial consultative visit with a patient is to triage the likelihood that the patient would benefit from behavioral health services within primary care. The BHC is advised to consider referring patients who clearly have serious mental health disorders for specialty behavioral health care soon after the first triage visit. Primary indications that a patient should be referred for specialty behavioral healthcare is the patient's failure to respond to a reasonable regime of behavioral health consultation and the patient's interest in and clinical need for long-term intensive psychotherapy and pharmacotherapy.

Regardless of the BHC's assessment and recommendation for level of care, the BHC must always consider the patient's preference when determining whether to refer for specialty behavioral health care. If the patient requests specialty behavioral treatment, the BHC must respond to this request and discuss recommendations. Conversely, the BHC may encounter the situation wherein he/she has determined that specialty behavioral health care is indicated, but the patient refuses to be referred for specialty behavioral health care. In these cases, the BHC may elect to continue to see these patients but must remain mindful that the focus and level of services provided must remain commensurate with the BHC's role in primary care and should not extend beyond that scope of care. In such instances, the BHC may continue to follow the patient but must explicitly inform the patient of the recommendation for specialty behavioral healthcare and document that the patient declined the recommended intensity of treatment. The BHC must also communicate this information to the provider as the provider remains responsible for managing the patient's psychiatric condition.

Patients who are being seen in specialty behavioral health care clinics can also access the BHC services at SCH&DC. Many times, patients find the focused approach of the behavioral health consultation to be a helpful supplement to traditional therapy. Additionally, a service is provided to the provider, enabling him or her to understand the patient better in order

to offer optimum medical care. BHC often bridge the gap between the medical and psychiatric services patients receive.

Return to Provider and BHC Following Treatment in the Specialty Behavioral Health Service

Some patients who are discharged from the specialty behavioral health care service remain on a maintenance regimen of psychotropic medications. Such patients may be referred back to the primary care service for management of their psychiatric condition. In this way, such patients may be "recaptured" by the BHC to assist the provider in providing maintenance psychiatric care. In addition, the BHC can promote maintenance of clinical gains achieved during the course of treatment in specialty behavioral healthcare, as well as assist in prevention of relapse or recurrence of illness. Finally, the BHC can be available to triage and evaluate whether a patient should be referred back to the specialty behavioral health service if a patient's condition deteriorates or the provider questions whether the patient's psychiatric condition can be treated adequately within the primary care service.

Patients in Crisis

When a patient in crisis (i.e., imminently suicidal or homicidal) presents to the primary care service, the BHC should intervene immediately and attempt to manage the crisis within the primary care service. If the patient cannot be stabilized quickly, the BHC should follow SCH&DC's policy, and may seek assistance from another BHC and/or one of the clinic's social service workers and notify 911 as appropriate.

Documentation

The BHC will record all documentation in the patient's primary care chart. All referrals should be documented in the Plan section of the ~~SOAP~~ visit note. This template is available in the EMR and the same template is used for initial visit and progress notes.

1. **All ~~SOAP~~ Visit notes** should contain the following information:
   - The referral problem
   - The patients primary care provider
   - Pertinent assessment and screening information
   - Follow up date, if applicable
   - ~~Axis I - V diagnosis~~ Applicable ICD10 diagnoses
   - Recommended interventions and who is to execute them (e.g., BHC, provider, patient)

2. **Progress Note** includes**:**

   - Notes updating patient's condition, situation or other factors related to holistic care.
   - Assessment of the patient's adherence and response to interventions initiated by BHC and/or provider;
   - Recommendations on continuing or modifying intervention strategies (i.e., modifications to existing treatment plan);
   - A statement of who is responsible for executing intervention strategies (e.g., BHC, the patient, the provider)

BHCs must comply with all regulations regarding reportable events, regardless of level of sensitivity of this information. ***It is the responsibility of the provider who identifies the reportable event to act upon this information***. BHCs should not push this responsibility to the provider if the BHC identifies the event. Similarly, the BHC should not accept this responsibility from the provider if the provider identifies this information.

Providing Feedback to the Providers

BHCs are encouraged to provide feedback **in-person** and on the **same day** as the patient contact occurs. Since the hallmark of behavioral health consultation is to serve as a consultant to the provider, providing feedback to the referring provider is one of the BHC's most important functions. Written feedback comes in the form of the consultation/progress note. In addition to the electronic medical chart, the BHC has several options for same-day feedback: verbal (in-person), or practice partner messaging (over the secured server). In practice, some combination of these options will likely occur and some providers may prefer one method to others. Critical aspects of delivering feedback is to do so in a succinct and timely fashion, as well as to keep the interaction with the provider brief and to the point.

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Childhood Immunizations, Vaccine Information Statement, and Consent Policy

Policy Category: **10.0.05 Clinical**
Policy Owner: **Director of Clinical Operations~~Clinical Operations Manager~~**
Origination Date: **08/27/2012**
First Date Approved by Board of Directors: **08/27/2012**

Policy:
Parent/legal guardian will be provided with the latest release of appropriate Vaccine Information Statement (VIS) prior to vaccination of child in compliance with CDC recommendation and Federal Law.

Purpose:
Education of parents/legal guardians prior to vaccination of child with any immunization to ensure proper consent is obtained prior to administering vaccines to a minor.

REVIEWED: 10/18/2012, 01/10/2014, 04/08/2016, 04/14/2017, 09/01/2018, 10/01/2019, 09/01/2020, 09/02/2021, 08/26/2022

REVISED: 10/22/2012, 01/20/2014, 09/24/2018, 10/28/2019, 09/28/2021

Signatures:

_____ _____ Date:
Kimberly Wetherhold, Board Chair James Yoxtheimer, President & CEO

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Controlled Substance Policy

Policy Category:	**10.0.08 Clinical**
Policy Owner:	**Director of Clinical Operations~~Clinical Operations Manager~~**
Origination Date:	**08/27/2012**
First Date Approved by Board of Directors:	**08/27/2012**

Policy:

Controlled Substance Agreements (CSA's) will be initiated by the Susquehanna Community Health & Dental Clinic, Inc. (SCH&DC) provider when pain management requires a Schedule II, III, IV, or V drug.

Purpose:

To assure the appropriate medical use of controlled substances and prevent their diversion and abuse.

Process:

1. CSAs will be initiated by the provider when a patient's care plan includes prescription of Schedule II drugs.
2. CSAs may be initiated at the provider's discretion when a patient's care plan includes prescription of Schedules III, IV, and V drugs.
3. New CSA's will be done at least every 6 months along with a review of patient goals.
4. Clinical support staff will review the CSA with the patient and witness the patient's signature.
5. The following actions will result in the termination of the controlled substance prescription:
    a. Seeking or obtaining any controlled substance from a source other than their SCH&DC provider.
    b. Selling or distributing prescribed drugs.
    c. Attempts to forge or alter a prescription.
6. The following actions may result in termination of the controlled substance prescription:
    a. failing a drug screen
    b. refusing to present for a random drug screen
    c. refusing to present for a random medication count
7. If the decision is made to terminate the controlled substance prescription, the patient will receive written notification. The provider will continue to provider primary care for the patient and will continue to prescribe non-controlled medications. The provider has the discretion to provide a final prescription of the controlled substance based on clinical judgement.
8. The provider reserves the right to discontinue controlled substances based on their clinical judgement at any time.
9. If the patient has a history of belligerent noncompliance or abusive or threatening

behavior, they may be referred to the patient dismissal committee for review.

10. Illegal activity related to the prescription use, misuse, or diversion of a controlled substance will be reported to law enforcement.
11. Lost or stolen prescriptions of controlled substances will not be replaced under any circumstances.
12. CSA, violation of CSAs, and termination of CSAs will be documented in the EHR.

REVIEWED: 01/25/2013, 02/13/2013, 01/10/2014, 04/08/2016, 10/01/2018, 09/02/2019, 11/01/2019, 09/01/2020, 09/02/2021, 08/26/2022

REVISED: 01/28/2013, 01/20/2014, 10/22/2018, 09/23/2019, 11/25/2019, 09/28/2021

Signatures:

_____ _____ Date:

Kimberly Wetherhold Board Chair James Yoxtheimer, President & CEO

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CENTER, INC.

Telepsychiatry

Policy Category:	**10.0.53 Clinical**
Policy Owner:	**Behavioral Health Coordinator**
Origination Date:	**09/12/2019**
First Date Approved by Board of Directors:	**09/23/2019**

Purpose: To incorporate Telepsychiatry into River Valley Health and Dental Center (RVHDC) in an ethical and responsible manner.

Policy: River Valley Health and Dental Center (RVHDC) and its providers will operate its Telepsychiatry program in accordance with all payors, state, and federal regulations.

Population: RVHDC will provide Telepsychiatry services to children ages 4 and up (provided the child is deemed capable of participation), adolescents, and adults who are also served by members of the RVHDC medical staff.

Procedure:

Referrals –
Telepsychiatry at RVHDC will receive referrals from members of the center medical staff. When individuals are considered for psychiatry service, they will be provided with detailed information about all community services and initiatives, including the option of telepsychiatry within RVHDC. The individual, or guardian, will have the opportunity to ask questions about the process and view the space and equipment, if desired, to ensure a level of comfort with the service line.

Individuals enrolled in medical services at RVHDC who are also referred for psychiatry services are not required to participate in telepsychiatry services in this office.

Referrals from outside providers will be considered when those referrals are also to establish physical health care within the center.

Outside referrals for new-to-the-center patients will be scheduled with a medical provider prior to being scheduled for telepsychiatry.

Medical providers will enter a referral into their EMR and assign to BHC to determine insurance eligibility and outreach patient for intake/assessment.

Evaluation / First Visit
Initial telepsychiatry evaluations will be scheduled in one-hour appointments within the daily schedule. The number of evaluation slots per center day will be determined by mutual agreement between provider preference and center volume need.

The individual will be roomed by a Medical Assistant, Licensed Practical Nurse or Registered Nurse as designated by center daily schedule. All applicable biometric screening, medication reconciliation and quality measures will be entered in the EMR for provider review during the visit.

At the time of the first visit, the nurse or designee will explain and demonstrate the video connection. The center staff will introduce the individual to the telepsychiatrist and remain in the visit room until both the individual and the psychiatrist can confirm they are ready to proceed with the session without additional assistance.

During each session, evaluation, and medication check follow up, the telepsychiatrist will be connected to center staff via Teams. Center rooming staff can be immediately summoned by the individual in person or via skype by the telepsychiatrist if questions or concerns arise. If there is a clinical issue, if the individual becomes upset, angry or distraught, the Behavioral Health Consultant (BHC) will be available to speak face to face with the individual and provide guidance and intervention.

Medication Check / Follow-up Visits

Medication check visits will be scheduled in twenty-minute appointments for adults and 30 minute appointments for children/adolescents within the daily schedule. The number of medication check visits in a center day will be based on availability of time given the number of new patient visits during the center day.

The individual will be escorted to the telemedicine room by the nurse of designee. Vital signs and applicable health information will be obtained and entered into the EHR.

During each session, evaluation, and medication check follow up, the telepsychiatrist will be connected to center staff via Teams. Center rooming staff can be immediately summoned by the individual in person or via skype by the telepsychiatrist if questions or concerns arise. If there is a clinical issue, if the individual becomes upset, angry or distraught, the Behavioral Health Consultant (BHC) will be available to speak face to face with the individual and provide guidance and intervention.

Record-keeping

Medical records will be maintained in accordance with OMHSAS regulations. All center records will be stored within RVHDC's electronic health record. Protected health information will be shared only with necessary staff.

Permission to access client records is limited to staff who have direct therapeutic, supervisory, performance improvement, compliance, or administrative responsibility for treatment services.

Any information communicated between telepsychiatrist and office staff or patients and families and center staff will be documented within the RVHDC electronic health record medical messages.

Case records are confidential, and access is granted only to persons on a "need-to-know" basis. RVHDC staff and psychiatrist will only use or disclose the minimum amount of protected health information (PHI) necessary to accomplish a specific task. RVHDC requires the compilation, maintenance, and dissemination of each client's record as a mandated and centrally imperative function in the delivery of treatment services.

Attendance and Refills

In order to safely adhere to telepsychiatry plans of care, attendance at all scheduled visits is expected during enrollment in telepsychiatry services at RVHDC. However, RVHDC recognizes that absence may be unavoidable at times.

If an appointment is cancelled by the individual, medications will be refilled by a RVHDC provider according to the treatment plan outlined by the telepsychiatrist. The refill will provide enough medication until rescheduled visit. The individual must then present at the next scheduled visit to receive a next refill. A second consecutive cancelled visit will require the individual to present for a rescheduled appointment to receive prescription refills.

In cases when refills are requested to bridge until next scheduled visit, telepsychiatry will follow RVHDC policy and request that individuals allow 48-72 hours for refills to be processed. Should refill requests be made on a non-center day for the telepsychiatrist, the request will be entered in medication messages in the electronic health record. It may be necessary for nursing or BHC to call the telepsychiatrist to request they check and respond to medication messages.

Should an established individual no show / no call a scheduled visit, no refills will be given until the individual reschedules and presents for a new visit. ~~New visit will be scheduled according to provider availability.~~ In these cases, it may be possible for BHC or nursing to see the individual and assess safety, symptoms and vital signs. BHC or nursing will then outreach the telepsychiatry provider to determine best course of action. PCP may be consulted for refills only if telepsychiatry provider is unavailable for any reason. In such cases, PCP will act within clinical judgement, training and scope.

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Should an individual no show / late cancel a scheduled telepsychiatry evaluation, they will not be rescheduled with the telepsychiatrist until they attend a behavioral health visit with their PCP.

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For established telepsychiatry patients, ~~S~~should an individual incur two no show / no call absences (consecutive or non-consecutive) within a six-month period, the individual may be discharged from telepsychiatry services. When a patient is discharged from telepsychiatry for

non-attendance, they will be eligible to re-enroll in telepsychiatry services following a six-month period.

Discharge from telepsychiatry services will not automatically result in discharge from RVHDC. Individuals who are discharged from telepsychiatry services may remain enrolled in medical and dental services with RVDHC, consistent with the Patient No-Show and Non-compliant Patient Policies.

Patients lost to care will be eligible to return to services consistent with provider discretion and if they have not been discharged from all center enrollment due to inappropriate conduct in or toward the center.

Intra-visit Questions and Emergencies
In the event of medication emergencies, patients will report to the nearest emergency department.

Telepsychiatry provider will provide individuals served with education and instruction regarding risks, benefits and side effects of all prescribed medications in order to minimize intra-visit questions. Nevertheless, routine and emergent questions are possible and likely.

Telepsychiatry provider will be thorough in all documentation, including in assessment and plans. In cases of intra-visit questions, it may be possible for BHC or nursing to see the individual and assess safety, symptoms and vital signs. In those cases, BHC or nursing will outreach the telepsychiatry provider to determine best course of action. PCP may be consulted only if telepsychiatry provider is unavailable for any reason. The telepsychiatrist documentation will outline clear contingencies to assist, if appropriate, with PCP decision making, should non-emergent intra-visit issues arise. In such cases, PCP will act within clinical judgement, training and scope.

Quality Assurance
Individuals enrolled in telepsychiatry services will be periodically surveyed regarding their satisfaction with the service line in accordance with RVHDC quality assurance guidelines.

Conduct
Individuals enrolled in telepsychiatry with RVHDC are expected to maintain respectful and courteous behavior toward all center staff, both in person and on the phone. Violence, threats of violence, vandalism, stealing from the center, carrying weapons onto the premises will not be tolerated and may result in termination from telepsychiatry services.

Drugs of Abuse Urine screen (DAU) – DAU may be required of individuals enrolled in telepsychiatry services at RVHDC. This will be determined by the telepsychiatry provider's discretion.

It may be required that DAU be observed by a nurse or Medical Assistant.

If DAU screens positive for substances which should not appear in the individual's sample or screens negative for prescribed medications that should appear in the individual's sample, telepsychiatry provider discretion will determine any changes in plan of care, including but not limited to additional confirmatory testing and discontinuation of enrollment in telepsychiatry services with RVHDC.

Adjunct therapy
As is the case with all individuals served by RVHDC medical staff, those who desire individual therapy will be assessed by BHC to determine an appropriate service provider.

REVIEWED: 11/01/2020, 12/15/2021

REVISED: 12/28/2021

Signatures:

_____ _____ Date:
Kimberly Wetherhold, Board Chair James Yoxtheimer, President & CEO

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Medical Appointment Policy and Procedures

Policy Category:	**12.0.01 Patient Flow**
Policy Owner:	**Front Office Manager~~Director of Clinical Operations Clinical Operations Manager~~**
Origination Date:	**08/27/2012**
First Date Approved by Board of Directors:	**08/27/2012**

Policy:

Susquehanna Community Health & Dental Clinic, Inc. (SCH&DC) has created this policy to ensure that our patients are able to schedule appointments with their primary provider in a timely and efficient manner in order to maximize access and continuity of care for both routine and urgent needs. All attempts are made to satisfy patient requests to improve access. SCH&DC reserves the right to change or amend this policy at any time.

It is the policy of SCH&DC to accommodate same-day appointments for both urgent and routine needs. The goal of SCH&DC is to turn no patient away. It is the policy of SCH&DC to provide care to all individuals, regardless of ability to pay. SCH&DC staff will manage patient requests in a confidential, efficient, and courteous manner.

Procedure:

A. Patients are scheduled with their Primary Care Provider (PCP) or regular clinician:
   1. New patients will be encouraged to choose their primary care provider within SCH&DC according to the "Selecting a Primary Care Provider" policy.
   ~~2.~~ New patients are offered an appointment no later than 30 days from when a release of information is received. ~~New patient appointments are scheduled within 30 days of the request.~~
   ~~3.~~2. Patient's PCP will be documented in the electronic medical record.
   ~~4.~~3. At each visit, staff will verify primary care provider and offer an appointment with the PCP, if available.
   ~~5.~~4. Patients are registered according to SCH&DC policies with due regard for the protection of the patient's privacy and in accordance with SCH&DC policies on Patient Confidentiality. ~~Refer to "Patient Registration Process" for details.~~
   ~~6.~~5. Patients will be scheduled with another provider only when an urgent need arises that requires the patient to be seen prior to their PCP's next available appointment.
   ~~7.~~6. Scheduling data is reported monthly to monitor access. Data includes evaluation of no-show rates, new patient appointments, and visits with PCP to ensure meeting of practice standards and identify opportunities for improving access to care.
   ~~8.~~7. Blocked out/unavailable appointment slots may not be overwritten without permission from the Front Office Manager ~~or Director of Clinical Operations Clinical Operations Manager.~~
B. Siblings
   1. Multiple siblings are scheduled with their PCP. No more than two siblings can be scheduled consecutively per provider. ~~by office assistants. Multiple siblings are scheduled with their PCP.~~

C. Same-Day Appointments:
   1. SCH&DC provides walk-in access for patients with same-day needs. Patients with urgent or routine complaints will be offered an appointment with their PCP or may be seen in Express Care. Patients may be scheduled for same-day appointments every day during clinic hours.
   2. If patients call requesting same-day appointment, staff will inquire regarding the chief complaint. If the complaint can be treated by Express Care, according to guidelines, staff will direct patient to Express Care. If a patient has a complex medical condition or complaint, staff will transfer the call to the Team Nurse. Nursing will assist the patient following "Nurse Triage" policy.
   3. If patient prefers to be seen by their PCP, staff will schedule patient with the next available appointment with their PCP.

REVIEWED: 04/08/2016; 03/30/2017, 07/23/2019, 07/08/2020, 07/01/2021, 08/29/2022

REVISED: 08/26/2019, 07/27/2020, 08/24/2021

Signatures:

_____ _____ Date:

Kimberly Wetherhold, Board Chair James Yoxtheimer, President & CEO

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

New Patient Registration Guidelines

Policy Category: **12.0.05 Patient Flow**
Policy Owner: **Front Office~~Clinical Operations~~ Manager**
Origination Date: **08/27/2012**
First Date Approved by Board of Directors: **08/27/2012**

Policy:

Susquehanna Community Health & Dental Clinic, Inc. (SCH&DC) has developed this policy to outline the process for registering a new patient and gathering demographics, insurance, and medical history for new patients, before their arrival at the first appointment.

Process:

- New patients will be advised to come in to complete a release of information immediately or directed to the Center's website to complete electroncially to obtain medical records prior to the first visit. ~~and complete the intake form. If new patients are scheduled more than one week out the intake form and Release of Information form will be sent to the patient electronically~~. New patents will be offered an appointment no later than 30 days from the date the ROI is received. Exceptions to this process would include new patient hospital follow-ups and new patients referred to the Center from organizations such as homeless shelters and residential housing programs which will be scheduled within 7-10 days.
- All incoming records are added to the EHR including newborn records, intake forms, ROI, immunizations and other pertinent medical information.
- If RVHDC does not receive records 3 days prior to the new patient visit, rooming staff, when scrubbing, will send a high priority message to the office assistant to follow-up. All new patients with acute issues will be directed to Express Care services.
- ~~All incoming records are added to the EHR including newborn records, intake forms, ROI, immunizations and other pertinent medical information. If records are not received by new patient appointment, clinical support staff will outreach the appropriate organization for necessary information. If appropriate records are not received the appointment may need to be rescheduled. Every effort will be made to address the patient's acute concerns as much as possible without records.~~
- After a new patient is checked in, new patient packets are provided. New patient orientation includes review of patient rights and responsibilities, services provided by SCH&DC, how to contact SCH&DC during and after office hours, process for transferring records, the medical home model of care, as well as assess patient

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REVIEWED: 01/10/2014, 02/28/2014, 04/08/2016, 03/30/2017, 07/05/2018, 08/01/2019, 07/08/2020, 07/01/2020, 07/26/2021, 08/29/2022

REVISED: 03/17/2014, 07/23/2018. 08/26/2019

Signatures:

_____ _____ Date:
Kimberly Wetherhold~~John Boll, Jr. D.O.,~~ Board Chair James Yoxtheimer, President & CEO