Eastern Band of Cherokee Indians

Public Health & Human Services

DIVISIONAL POLICY and PROCEDURES

REVISION / APPROVAL CHANGE LOG & SIGNATURE SHEET

Policy Name	Policy Number	Action	Effective Date	Revision. Date	Last Approved	Current App. Date	Sec. Initials
Divisional Policy Procedure	DAP01	Addition	10/01/19		10/1/19	10/19/20	
Absenteeism	DAP02	Addition	10/01/19		10/1/19	10/19/20	
Professional Attire	DAP04	Addition	10/01/19		10/1/19	10/19/20	
Program Administrative Leave Request	DAP06	Addition	10/01/19		10/1/19	10/19/20	
Tobacco Free Campus Policy	DAP07	Addition	10/01/19		10/1/19	10/19/20	
Divisional Exit Process	DAP08	Addition	10/01/19		10/1/19	10/19/20	
Human Subject Research Protect	DAP09	Addition	10/01/19		10/1/19	10/19/20	
Admin. Leave for Physical & Health Education	DAP10	Addition	10/01/19		10/1/19	10/19/20	
Supply Inventory Policy	DAP11	Addition	10/01/20			10/19/20	
Health Information Confidentiality and Security	DAP12	Addition	10/12/20			10/19/20	
Adverse Weather Emergency Response	DEP01	Addition	10/01/19		10/1/19	10/19/20	
Emergency Shelters Nursing Staff	DEP02	Addition	10/01/19		10/1/19	10/19/20	
Continuity of Operations Plan	DEP03	Addition	10/01/19		10/1/19	10/19/20	
Essential Supplies and Grocery Assistance	DEP04	Addition	10/19/20			10/19/20	
NIMS | ICS Training	DTP01	Addition	10/01/19		10/1/19	10/19/20	
CPR	DTP02	Addition	10/01/19		10/1/19	10/19/20	
First Aid Training	DTP03	Addition	10/01/19		10/1/19	10/19/20	
Respiratory Protection Training & Fit-Testing	DTP04	Addition	10/01/19		10/1/19	10/19/20	
Bloodborne Pathogen Training	DTP05	Addition	10/01/19		10/1/19	10/19/20	
HIPAA/Privacy & Security /Confidentiality	DTP06	Addition	10/01/19	10/01/20	10/1/19	10/19/20	
Compliance Plan Training	DTP07	Addition	10/01/19	10/01/20	10/1/19	10/19/20	
Divisional Flu & TB Policy	DSP01	Addition	10/01/19		10/1/19	10/19/20	
Records Retention	DRC02	Addition	10/01/19		10/1/19	10/19/20	
Social Media Account Approvals Process	DAP14	Addition	10/01/19		10/1/19	10/19/20	
Social Media Account Program Use	DAP15	Addition	10/01/19		10/1/19	10/19/20	
Social Media Account Personal Use	DAP16	Addition	10/01/19		10/1/19	10/19/20	
Quality Improvement	DQI03	Addition	10/01/19		10/1/19	10/19/20	
Performance Management PM System	DQI01	Addition	10/01/19		10/1/19	10/19/20	
PHHS Building Key Issuance & Maintenance	DAP13	Addition	12/14/20		12/14/20		
Conflict of Interest	DRC03	Addition	01/25/21		01/25/21		
Ethical Issue Reporting and Review Process	DRC04	Addition	01/25/21		01/25/21		
Approval of Divisional Plans and Procedures	DAP17	Addition	11/16/20		11/16/20		
Public Health Surveillance	DEPI01	Addition	04/15/21		04/15/21		
PHHS Data Sharing Policy	DAP18	Addition	02/24/21		02/23/21		
24/7 Contact and Services Policy	DEP05	Addition	06/11/21		06/11/21		
Safety Complaint Investigation Process	DENV01	Addition	06/11/21		06/11/21		
QIPM Plan	PLAN	Addition	05/10/21		05/10/21		
Tactical Communications Plan	PLAN	Addition	06/16/21		06/16/21		

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ADMINISTRATIVE POLICIES & PROCEDURES

POLICY #: **DAP01 Divisional Policy Procedure**

SUBJECT: Policy Approval Processes for acceptance, review or denial of PHHS policies.

PURPOSE: Standard operating procedure for approval of programmatic and divisional Public Health and Human Services policies.

DEFINITIONS: "Committee or PNP" is the Policy and Procedure Committee
"RCD" is the Regulatory and Compliance Department

POLICY STATEMENT: The EBCI PHHS Division will follow the systematic procedures identified below to gain approval of both programmatic and divisional level policies and procedures. This initiative will seek to establish oversight, solidify processes, and streamline policy approvals necessary to ensure reliable system processes and quality services are provided by the Division.

PROCEDURE/ GUIDELINES:

1. PHHS programs seeking approval of policies shall submit them to the Regulatory and Compliance Department Compliance Officer.
    a. If the policies being submitted are program specific policies, they will be required to have the Manager's signature upon being received.

    The policy will be tracked and processed by the department until returned to the submitting program. A department representative will be notified by a compliance officer to perform a necessary evaluation of the document/s.
    b. RCD will perform oversight functions to evaluate the policy as to proper form, potential duplication of policies, and content of the document to ensure its conformity to relevant Federal, State, Tribal, and accrediting regulations.
    c. Revision suggestions will be returned to the original author of the policy prior to being sent for final review and approval.
    d. All policies published within the divisional policy manual will be submitted to the PHHS Secretary annually for final review and approval.
2. Once received by a compliance officer from the RCD Department will complete their oversight functions. After RCD has determined that the policy satisfactorily meets evaluation criteria, a compliance officer will ensure it is delivered to the appropriate reviewer.
    a. If a program policy, the Divisional Director responsible for the respective program for final signature.
    b. If a Divisional policy, the next available Executive Team meeting for final signature.
3. Once the final signature has been obtained, policies will be sent back to Regulatory and Compliance to be directed by a compliance officer for distribution to the submitting program.
    The committee will provide oversight to ensure the Divisional Policy Procedure is being conducted as required by this policy. Committee representatives may report substantial non-compliance with the requirements of this policy to the Secretary of Public Health and Human Services and or the Regulatory and Compliance Committee.

4. Review of all policies (both program and divisional) will be conducted on an annual basis. All approved policies shall be reviewed as follows:

    a. Program policies annual review shall be conducted by program managers.
    b. Divisional policies annual review shall be conducted during Executive Team meeting.

AUTHORITY:

ATTACHMENTS:

POLICY #: **DAP02 Absenteeism**

SUBJECT: Absenteeism

PURPOSE: To define specific policies/procedures for PHHS as related to absenteeism.

DEFINITIONS:

Absence: Failure to report for a scheduled day of work with less than 24-hour notice to your supervisor excluding bereavement or on a covered leave such as military, jury duty or FMLA.

No Call/No Show: Failure to call and report your absence to your supervisor or person designated as being responsible for the department where you work within 2 hours after your scheduled shift has started. Each day that an employee does not report for work and does not call is s a separate occurrence even if they are consecutive days.

Occurrence: Each absence that may result in one or more days of work missed in a row. All occurrences that result in 3 or more days of missed work will automatically require a doctor's note to return to work. Any occurrence that results in 7 days missed will require a report to Human Resources for possible FMLA coverage.

Excessive or patterned absences: Examples are always having 2 day of absences with each occurrence, calling out on the Friday before or the Monday after a weekend.

Other Attendance Related Violation: Leaving the campus for meal break without supervisor notification.

POLICY STATEMENT: It shall be the policy of PHHS to supplement the EBCI personnel policy on absenteeism. It is necessary for all staff to be present to work on time and ready to carry out their duties at the beginning of their shift.

Last 12 months/Rolling Calendar: Looking back in time twelve months from the occurrence being referred to.

Shift: Specific time you are assigned to be at work, generally 7:45 to 4:30 p.m.

PROCEDURE/ GUIDELINES:

AUTHORITY:

ATTACHMENTS:

POLICY #: **DAP04 Professional Attire**

SUBJECT: Professional Attire

PURPOSE: Define acceptable clothing for professionals who come in direct contact with patients and customers

DEFINITIONS: N/A

POLICY STATEMENT: Personal appearance, dress, grooming, and personal cleanliness standards contribute to the professional image presented to customers, visitors, and colleagues. While conducting tribal business, employees are expected to present a clean, neat, and professional business-like appearance. employees should dress according to the requirements of their positions as determined by the appropriate supervisor. **PROCEDURE/ GUIDELINES:**

1. Employees involved in direct patient/client care are required to dress in professional attire and present a professional appearance, regardless of the circumstances. *
2. Social activities are **not exceptions** if you are providing direct patient care during that day. You may, however, change clothes after patients are no long in the facility if social or physical activities are planned.
3. Some employees are required to wear uniforms. (Tribal In-Home Care, Clinics)
4. Administration understands that inclement weather will allow variations in dress code policy.

*NOTE: Administration does not consider the following to be professional, business like attire: jeans, pants that fall below the waistline with any portion of the midriff showing, shorts, sweat pants, overalls, short skirts, cropped pants higher than mid-calf, flip flops, and shirts with the sleeves cut off.

Fridays are considered “Jean Fridays”. No pants that fall below the waistline with any portion of the midriff showing, shorts, sweat pants, overalls, short skirts, cropped pants higher than mid-calf, flip flops, and shirts with sleeves cut off.

AUTHORITY:

ATTACHMENTS:

POLICY #: **DAP06 Program Administrative Leave Request**

SUBJECT: Administration Leave Request for EBCI Employees

PURPOSE: Defines the process for requesting administrative leave for tribal employees for PHHS activities

DEFINITIONS: N/A

POLICY STATEMENT: All requests for Administrative Leave for Tribal Employees must be approved by the Public Health and Human Services Administration. Program managers must request Administrative Leave for Public Health and Human Services or other tribal employees at least four weeks in advance of any planned activity. Administrative Leave must be requested and approved by the manager of the program.

PROCEDURE/ GUIDELINES:

Procedure:

1. The manager of the program (or their designee) requesting Administrative Leave must complete *a Request for Administrative Leave* for Employees form (typed)
2. The form is turned into the PHHS Executive Secretary four weeks before the planned activity.
3. All requests will be processed during the weekly PHHS administration meeting.
4. All approved requests will then be passed on to Exec for final approval.

AUTHORITY:

ATTACHMENTS: REQUEST FOR ADMINISTRATIVE LEAVE FOR TRIBAL EMPLOYEES FORM

POLICY #: **DAP07 Tobacco Free Campus**

SUBJECT: Tobacco Free Campus Policy

PURPOSE: The purpose of this policy is to establish a non-tobacco use policy that is communicated and enforced throughout the organization's buildings and campuses. This policy is intended to prohibit the use of tobacco products and reduce risks to patients, including possible adverse effects on treatment; reduce risks of passive smoking for others; and reduce the risk of fire. The purpose of this policy is also to outline the process to accommodate individuals who require tobacco dependence support

DEFINITIONS:

- "Tobacco" is defined as a preparation of the nicotine-rich leaves of an American plant, which are cured by a process of drying and fermentation for smoking or chewing.
- "Tobacco use" is defined to include smoking, chewing, dipping or any other use of tobacco products.
- "Smoking" is defined as inhaling, exhaling, burning, or carrying any lighted cigar, lighted cigarette, or other lighted tobacco product in any manner or form.
- "Spit tobacco" is defined as any tobacco product that is chewed, dipped, spit, or held in the mouth in any manner or form.
- "Tobacco product" is defined to include cigarettes, e-cigarettes, cigars, blunts, bidis, pipes, chewing tobacco, snuff, and any other items containing tobacco.
- "Bidis" are small, thin hand-rolled cigarettes, often flavored, imported to the United States. They have very high concentrations of nicotine, tar, and carbon monoxide.
- "Blunts" are cigars that have been hollowed and refilled with marijuana.
- "e-cigarettes" also known as e-cigs, electronic nicotine delivery systems, vaporizer cigarettes, and vape pens are battery-operated device that emits doses of vaporized nicotine, or non-nicotine solutions, for the user to inhale. It aims to provide a similar sensation to inhaling tobacco smoke.
- "Employee" is defined as any individual employed part-time, temporarily or full-time, or contracted with Eastern Band of Cherokee Indians PHHS Division
- "Campus" is defined as property owned or leased by the EBCI Public Health and Human Services (PHHS) for use as specified above, to include buildings and grounds, parking lots, walkways, ramps, and all EBCI PHHS vehicles.

POLICY STATEMENT: For fire safety and health reasons staff, patients, and visitors are prohibited from using tobacco products on the PHHS campuses

PROCEDURE/ GUIDELINES:

- "Tobacco-free Campus" signs will be posted at the entrances to the Public Health & Human Services (PHHS) campuses, patient and employee parking areas (where applicable), and PHHS facilities.

- "No Tobacco" and/or Tobacco-free Campus/Facility signs shall be posted in conspicuous areas inside PHHS facilities.
- All staff are responsible for reporting violations of this policy and the responsibility for enforcement shall remain with management
- Copies of this policy will be distributed to ALL employees and employment applicants when interviewed

Public Health & Human Services Employees:

- Are prohibited from using tobacco products on PHHS Campuses. This includes, on or near the fringes of the boundaries of campuses, in Tribal or Government vehicles, or within private vehicles parked on PHHS campuses.
- Will be provided the opportunity to participate in services offered through the Employee Assistance Program
- Will be provided education and/or access to resources available for smoking cessation.
- Any violation of this policy will be reported to the employee's immediate supervisor who will follow the Corrective Action Procedures in the EBCI Personnel Policies and Procedures manual. Violation of this policy would be considered a Schedule II and/or III Offense with consequences of written reprimand to termination. Violations would be subject to progressive disciplinary actions.

Patients and/or Visitors:

- Visitors and/or patients are prohibited from tobacco use on PHHS campuses.
- If the patient uses tobacco products, they will be provided information on nicotine replacement therapy and tobacco use cessation programs. Tobacco use, education, request for nicotine replacement therapy, tobacco use cessation questions will be documented in the patient's record

AUTHORITY:

ATTACHMENTS:

POLICY #: **DAP08 PHHS Divisional Exit Process**

SUBJECT: PHHS Divisional Exit Process

PURPOSE: To outline a process during an employee's termination/resignation by which PHHS can ensure, collection of tribal property or access to tribal property/work product, identification of compliance concerns through a compliance questionnaire, feedback on quality indicators through managerial assessments, and adherence to EBCI Tribal policy.

DEFINITIONS:

PHHS Exit Interview: an interview with an employee during termination (either involuntary or voluntary), to discuss the employee's reasons for leaving, their experience of working for the organization.

POLICY STATEMENT:

Upon termination (either involuntary or voluntary) of PHHS employees, the program's supervisors, managers, directors or authorized designee shall be responsible for overseeing the collection of tribal property or denial of accesses to property/work product and ensuring that terminating employees are provided the opportunity for managerial and compliance feedback.

PROCEDURE/ GUIDELINES:

Prior to the termination of an employee, the manager shall ensure that a PHHS Employee Exit Packet is utilized. The packet will contain the following forms:

- Access and Property Control: A property control checklist, to be completed in conjunction with exiting employee and supervisor or manager.
- Employee Section: A Managerial Assessment, to be completed by the exiting employee and returned in a sealed packet.
- Compliance Section: A Compliance Assessment, which shall be offered in an interview format with an RCD Compliance Officer. If, because of time constraints or interview refusal, an in-person interview is not possible, then the Compliance Assessment is to be completed and returned in like manner and simultaneously with the Managerial Assessment.

Supervisors, managers, or directors shall notify RCD immediately of any foreseen terminations so that a timely Compliance Assessment interview can take place.

Upon completion of the Exit Packet, and no more than 72 hours after an exiting employee is terminated, the packet shall be delivered to the PHHS Human Resource Coordinator. The Coordinator will provide RCD an opportunity to review the Compliance Assessment if not done so prior to receiving the packet. The packet shall be kept in the exiting employee's personnel file housed by the PHHS HR Coordinator.

Failure to conduct an Employee Exit Interview may result in corrective action for the exiting employee's supervisor, manger or director.

AUTHORITY: PHHS Administration, Directors, Managers and RCD.

OVERSIGHT: RCD may conduct random file audits of employee's reported to have been terminated or resigned.

ATTACHMENTS:

POLICY #: **DAP09 Human Subjects Research Protection**

SUBJECT: Human Subjects Research Protection

PURPOSE: To ensure that PHHS respects the purpose of the Institutional Review Board (IRB) in the protection and rights of the safety and welfare of research subjects.

DEFINITIONS: Refer to IRB Operations Manual

POLICY STATEMENT: As a combined Public Health and Human Services organization, PHHS may have occasion to implement or participate in research that involves human subjects in order to benefit the Tribe. To assure protection of human subjects, PHHS will adhere to the highest ethical standards and will comply with The Cherokee Code and the operations of the EBCI Cultural & Medical Institutional Review Boards. The MIRB is registered with US DHHS OHRP as a Tribal IRB. PHHS will assure seamless integration of any research activities with the CIRB and MIRB and will follow the procedures outlined by the MIRB Operations Manual, which is based on OHRP requirements.

PROCEDURE/ GUIDELINES: The procedure for submission of medical, behavioral, or clinically related research proposals in EBCI is as follows:

AUTHORITY:

AUTHORITY: The Cherokee Code, Ch. 70, Sec. 70-3

ATTACHMENTS: EBCI Medical Institutional Review Board Operations Manual

EBCI MIRB Process Flowchart (Pg. 66, Divisional Policy Manual)

EBCI MIRB Manual
FINAL Rev 062520.do

REFERENCES: EBCI Medical Institutional Review Board Operations Manual

POLICY #: **DAP10 Administrative Leave for Physical and Health Education**

SUBJECT: Admin leave for Physical Activity and Health Education

PURPOSE: To provide a guideline for Employees to request, utilize, and record admin leave for Physical Activity and Health Education.

DEFINITIONS:

POLICY STATEMENT: As a division, Public Health and Human Services work to encourage healthy eating habits, physical activity, a healthy weight, and addiction free living. Chief Richard Sneed has approved the use of admin leave in the amount of fifteen (15) minutes per day for all Tribal Employees. All participants will receive fifteen (15) minutes of administrative leave daily to be physically active or attend health-based education classes.

PROCEDURES: To enroll, participants must adhere to the following:

- Must have supervisor's approval.
- To utilize leave, employee must sign in with Cherokee Fitness Complex, CIHA, Cherokee Choices or an approved sign in station to verify attendance.
- Must record administrative leave on timesheet.
- Must complete a baseline survey.

AUTHORITY: EBCI PHHS Executive Committee

ATTACHMENTS:

POLICY #: **DAP11 Supply Inventory Procedure**

SUBJECT: Supply Inventory Procedure

PURPOSE: To provide a guideline for Employees to track, store, and easily recognize when it is time to order more inventory.

DEFINITIONS:

POLICY STATEMENT: The Public Health and Human Services division strives to be as fiscally responsible as possible. Division supplies will be ordered based on need and usage. Procedures for storing and monitoring inventory are stated below.

PROCEDURE/ GUIDELINES:
A supply list for each program will be given to the MUNIS approver to begin the inventory process. The following procedures outline what occurs after items have been delivered.

- When supplies are received at PHHS, two employees should compare the inventory based on order sheet and the materials packing list (making sure the order is correct).
- Have both employees sign the order sheet confirming the contents.
- Inventory will be placed in its proper storage space.
- Once an item is nearing the end of its supply, a notice in the form of an email or phone call must be made to the supervisor letting them know. (this allows for everyone to be on the same page when it comes time to order more supplies)
- Monthly supply updates are to be given to supervisors (inventory checks).

AUTHORITY: Operations Director of PHHS, Business Director of PHHS

ATTACHMENTS:

REFERENCES:

POLICY #: **DAP12 Health Information Confidentiality and Security including**

SUBJECT: Health Information Confidentiality and Security including HIPAA

PURPOSE: This policy will be used as guidance for the standards adopted by PHHS regarding HIPAA and confidentiality practices within the division. The purpose of the Public Health & Human Services (PHHS) Division use and disclosure policy is to set forth the requirements under the Health Insurance Portability and Accountability Act (HIPAA) for privacy protections of individually identifiable health information (IIHI) by recognizing circumstances when it is permissible to use IIHI within the Division and when it is permissible to disclose IIHI outside the Division, including certain limitations and protections that must be applied to all health information.

DEFINITIONS:

Breach: The acquisition, access, use, or disclosure of protected health information (PHI) in a manner that compromises the security or privacy of the PHI.

Confidential Information: Includes all client employee, provider, and hospital information acquired by staff. This includes verbal, written or electronic information obtained or otherwise recorded in any form.
HIPAA: Health Insurance Portability and Accountability Act
IIHI: Individually Identifiable Health Information

Minimum necessary: Limiting the use or disclosure of protected health information to the minimum amount of information necessary to accomplish the intended purpose of the use, disclosure, or request for information.

POLICY STATEMENT: PHHS protects the confidentiality, privacy and security of all client information according to state and federal law, The Cherokee Code, ethical guidelines, and industry best practices. This policy applies to each PHHS employee, intern, volunteer, student, allied health professional, medical staff, contractor, vendor and each must be familiar with, understand, and follow the procedures in this policy.

PROCEDURE/ GUIDELINES:

PHHS Staff must consistently ask, "Do I need to access this information in order to do my job?" If client information is not necessary to perform your job, do not access the information.

TYPES OF VIOLATIONS OR BREACHES

1. Inadvertent or unintentional violation of client privacy/security. Violations include but are not limited to:

- Inadvertent access to client records
- Leaving a logged-in computer unattended, even if client information is not visible

2. Actions or behaviors that are contrary to privacy/security policies or procedures or training on the topics, including careless accesses. Violations include (but are not limited to):

   - Discussing client information with others when not required for job Discussing client information in public areas

   - Leaving logged-in computer unattended in an accessible area with client information visible
   - Improperly disposing of confidential client information (e.g, not using paper shredder to destroy confidential information)

3. Intentional access, discussion or disclosure of client information for purposes other than client care or authorized job function. Violations include but are not limited to:

   - Looking up birth dates, addresses of friends or relatives
   - Accessing and reviewing a record of a client out of concern, curiosity, or other inappropriate reasons with no need to know
   - Reviewing a high-profile client t's or public personality's records
   - Multiple violations of lesser offenses
   - Sharing of username and/or password
   - Sending identifiable client information via unsecured e-mail
   - Capturing an image of a client using an unauthorized personal device such as a cell phone.

4. Access, review or discussion of client information for personal gain or with malicious intent. Violations include (but are not limited to):

   - Compiling a mailing list to be sold
   - Reviewing client records to use information for personal reasons
   - Posting confidential information in any form to internet or on social media
   - Identity theft
   - Storing confidential information on a home computer unsecured

ACCESSING INFORMATION

A. General Confidentiality Requirements.

1. All Staff must sign and comply with a confidentiality agreement.

2. Staff position descriptions include language covering the expectation that each employee maintains client and appropriate organizational confidentiality.

3. Access to information is granted based upon employee's role. Only the "minimum necessary" information may be accessed, used, or disclosed, unless the information is (a) being used or disclosed for treatment purposes, (b) being disclosed to the individual who is the subject of the information, (c) being used or disclosed pursuant to a signed authorization from the client; or (d) disclosed as part of an investigation or is a disclosure required by law or compliance with HIPAA regulations.

B. Staff Access to and Confidentiality of Health Information:

1. PHHS direct customer care staff members are authorized to access client medical record information to provide care as required by their position and assigned position. PHHS staff and physician/provider access to client medical record information must only be made for the purposes of treatment, payment or healthcare operations, or when otherwise expressly permitted by law.

2. Any client information displayed or printed from an information system of PHHS should be treated as confidential medical record information. Printed material that is no longer needed should be disposed of in a manner consistent with other printed confidential information, i.e., shredded for confidential removal and destruction.

3. **Capturing/duplicating of any client information or client image via an unauthorized electronic device (such as, but not limited to, personal cameras, video cameras, or cell phones) is prohibited.**

C. Access to the network and specific applications require unique log-ins and passwords generated by the individual user. Passwords are to be used solely in conjunction with the performance of authorized job functions. All inquiries and entries performed under the user identification and password will reference the username.

1. A password must never be given to another individual. A password may be revised as deemed necessary by the user following an Information Technology Systems procedure.

2. Passwords will be deleted from use through Information Technology upon termination of employment or as deemed necessary by Human Resources or upon resignation/suspension of staff member.

3. As staff transfer within PHHS, access to applications/databases is revised and adjusted to reflect the new role.

D. Security of Electronic Health Records

1. Staff who have been authorized to read, enter, and/or update data as required by their job functions are responsible to comply with security controls and to protect confidential data from unauthorized disclosure or use.

2. Staff must exit applications when leaving computer workstations unattended. If not signed off, all computer workstations have an automatic sign-off. The timing of sign-off is determined by the system administrator/IT Division in conjunction with the application, operating system and/or platform parameters.

3. Information Technology and/or the individual database users/departments are responsible to secure the hardware and software used to run specific databases.

4. Information Technology has system integrity mechanisms in place against system crashes, lost/corrupt files, computer viruses, unauthorized access and sabotage for the major systems used by PHHS.

5. Database back-ups are completed on a regular schedule. The back-up copies are stored in a separate location from the computer.

HIPAA

The final Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule controls the use and disclosure of IIHI. Generally, covered health care components may not use or disclose IIHI except in ways identified in the Privacy Rule or when required or allowed by other federal or state laws. All other uses are prohibited, and barriers must be established to prevent any use and disclosure other than those permitted. 'Use' and 'disclosure' are significant terms that distinguish sharing of information within an organization (use) from releasing information outside the organization (disclosure).

The PHHS Division complies with North Carolina General Statutes and Administrative Rules mandating that all individual health information in its possession is confidential. The PHHS Division continues to comply with North Carolina statutes, which preempt HIPAA when state statutes are more stringent than HIPAA. The Division continues to adhere to all federal and state laws and regulations and program-specific requirements with respect to protecting the privacy of health information while fulfilling its

Public Health mission. In addition, and as part of its ongoing compliance, the Division follows NC DHHS department-level HIPAA policies, procedures, and practices, as applicable.

REPORTING

A. If you suspect that health client information confidentiality may have been compromised, notify any individual below immediately of the concern so that appropriate action can be taken.
    1. Your manager
    2. Human Resources
    3. Compliance Officers
        a. Brandy Davis, Lead Compliance Officer: (828) 359-1502
        b. Megan Yates, Compliance Officer: (828) 359-6195
        c. Compliance helpline: 1-800-455-9014
    4. Any member of PHHS leadership.

B. When a medical record has been inappropriately accessed or information has been inappropriately disclosed, the PHHS Regulatory & Compliance Department will conduct an investigation and PHHS Administration will determine if the client should be notified.

AUTHORITY:

ATTACHMENTS:


PHHS%20Confidentiality%20Attestation.d


HIPAA%20Confidentiality%20Attestation.d

REFERENCES:

North Carolina Department of Health and Human Services, Division of Public Health (2019). DPH Privacy Statement.

North Carolina Department of Health and Human Services, Division of Public Health (2019). DPH Privacy and Security Manual.

North Memorial Maple Grove Memorial Hospital. (2015). Health Information Confidentiality and Security (HIPAA) Policy.

The Cherokee Code.
https://library.municode.com/tribes_and_tribal_nations/eastern_band_of_cherokee_indians/codes/code_of_ordinances?nodeId=PTICHGODOEABACHIN

POLICY #: **DAP 13 PHHS Building Key Issuance and Maintenance Process**

SUBJECT: Public Health and Human Services (PHHS) Building Key Issuance and Maintenance

PURPOSE: To provide a guideline on the issuance and maintenance of building access keys to all PHHS Employees.

DEFINITIONS:

Key Holder- A person to whom a key has been issued.

POLICY STATEMENT: The Public Health and Human Services Division aims to provide optimal physical security and safety for building occupants and to protect the assets of the Eastern Band of Cherokee Indians (EBCI). This policy applies to all building(s) occupied by, and space(s) assigned to, PHHS employees.

PROCEDURE/ GUIDELINES:

1. KEY HOLDER ACCESS RESPONSIBILITIES

All employees are responsible for maintaining building security. A key holder is responsible for all keys issued to them. The duplication of keys or possession of any unauthorized keys is not permitted. The holder of keys to any PHHS facility assumes responsibility for the safekeeping of the key and its use. Should a loss occur, the department will be responsible for the financial impacts of re-keying an area. In an effort to minimize loss or misuse of keys, all key holders are strongly encouraged to keep PHHS keys in a secure location.

1.1 Employees will not loan or transfer their keys to any other individual.

1.2 Employees shall not unlock a building or room for another individual unless the individual is known by them to have authorized access to enter.

1.3 All PHHS issued keys must be returned to the Operations Director or Designee upon office move or vacating of a position in order to maintain accurate inventory.

1.4 Unauthorized persons or suspicious activities are to be reported to the EBCI Police Department and the PHHS Regulatory Compliance Department immediately.

1.5 Any found keys should be turned in to their Direct Supervisor who will in turn contact the PHHS Operations Director for directions.

1.6 Employees not in compliance with key and ID card policies may be subject to disciplinary action.

1.7 Employees may be charged a fee for the replacement of lost or misplaced keys.

2. KEY & ID CARD ACCESS REQUEST PROCESS

2.1 All key access requests must be submitted via the attached Key Access Request Form

2.2 Forms should be submitted in hard copy to the PHHS Operations Director or Designee.

2.3 Keys will be issued by the PHHS Operations Director or designee within two business days of receipt of an approved form.

2.5 Card access requests shall be made using the EBCI's Security and Surveillance policy on the issuance of access cards via the CWEB.

AUTHORITY: This policy on Key Control applies to all PHHS employees

ATTACHMENTS:

BUILDING/DOOR KEY REQUEST FORM

REFERENCES:

POLICY #: **DAP14 Social Media Account Approval Process**

SUBJECT: Social Media Account Approval Process

PURPOSE: To establish approval process for programs who wish to engage in business use of online social networking through the use of social media.

DEFINITIONS:

Social media: any electronic communication used for social networking and for sharing, discussing and/or developing ideas, information, and other content. Types of social media include, but are not limited to blogs, video- or photo-sharing sites, and social-networking sites. Examples of social-media sites include, but are not limited to Facebook, Twitter, Pinterest, LinkedIn, Instagram, YouTube, Flickr.

Social Networking: the creation, use, and maintenance of social media for communicating with and building online relationships for both business and personal use.

POLICY STATEMENT: Social media may be used for Social Networking by Public Health and Human Services (PHHS) employees for health promotion and prevention and are subject to the restrictions set forth in this policy. These restrictions are intended to ensure compliance with legal restrictions, privacy, and confidentiality agreements including; HIPAA, PHHS Compliance Plan, and the Eastern Band of Cherokee Indians (EBCI) Personnel Policy.

PROCEDURES:

New Accounts:

a. A Social Media Justification Form must be completed, signed, and submitted by the Program Manager to it the PHHS Public Relations Department for approval
    i. Facebook: Public Relations Department
    ii. Clearly define your objectives
    iii. Clearly explain to Administrators/Editors that overtime pay is not given if posting after work hours
    iv. Know your target audience
    v. Determine resource needs
    vi. Determine schedule and frequency posts

b. All Social Media account use privileges must be approved by the EBCI Information Technology Department following approval from the PHHS Public Relations Department

APPROVALS:

APPEALS:

REPORTING/STATISTICS:

AUTHORITY: EBCI PHHS Executive Committee

ATTACHMENTS:

POLICY #: DAP15 Social Media Account Program Use

SUBJECT: Social Media Account Program Use

PURPOSE: To establish approval process for programs who wish to engage in business use of online social networking through the use of social media.

DEFINITIONS:

Social media: any electronic communication used for social networking and for sharing, discussing and/or developing ideas, information, and other content. Types of social media include, but are not limited to blogs, video- or photo-sharing sites, and social-networking sites. Examples of social-media sites include, but are not limited to Facebook, Twitter, Pinterest, LinkedIn, Instagram, YouTube, Flickr.

Social Networking: the creation, use, and maintenance of social media for communicating with and building online relationships for both business and personal use.

POLICY STATEMENT: Social media may be used for Social Networking by Public Health and Human Services (PHHS) employees for health promotion and prevention and are subject to the restrictions set forth in this policy. These restrictions are intended to ensure compliance with legal restrictions, privacy, and confidentiality agreements including; HIPAA, PHHS Compliance Plan, and the Eastern Band of Cherokee Indians (EBCI) Personnel Policy.

PROCEDURES:

Accounts:

a. An approved Social Media Justification Form must be on file with public relations.
   i. Facebook: Public Relations staff must be made Administrators of ALL program Facebook Accounts
   ii. For all other Social Media Accounts that do not allow Public Relations staff to be made Administrators account Username and Passwords shall be given to the PR Staff. If account usernames and passwords are changed the PR staff shall be given the updated usernames and passwords immediately

iii. Clearly define your objectives
iv. Clearly explain to Administrators/Editors that overtime pay is not given if posting after work hours
v. Know your target audience
vi. Determine resource needs
vii. Determine schedule and frequency posts

APPROVALS: Public Relations Staff

APPEALS:

REPORTING/STATISTICS:

Submit data on weekly report

Facebook:

#Posts per week

#Likes

#Interacted/Engages

Twitter:

#Tweets sent per week

AUTHORITY: EBCI PHHS Executive Committee

ATTACHMENTS:

POLICY #: **DAP16 Social Media Account Personal Use**

SUBJECT: Social Media New Accounts

PURPOSE: To establish approval process for programs who wish to engage in business use of online social networking through the use of social media.

DEFINITIONS:

Social media: any electronic communication used for social networking and for sharing, discussing and/or developing ideas, information, and other content. Types of social media include, but are not limited to blogs, video- or photo-sharing sites, and social-networking sites. Examples of social-media sites include, but are not limited to Facebook, Twitter, Pinterest, LinkedIn, Instagram, YouTube, Flickr.

Social Networking: the creation, use, and maintenance of social media for communicating with and building online relationships for both business and personal use.

POLICY STATEMENT: Social media may be used for Social Networking by Public Health and Human Services (PHHS) employees for health promotion and prevention and are subject to the restrictions set forth in this policy. These restrictions are intended to ensure compliance with legal restrictions, privacy, and confidentiality agreements including; HIPAA, PHHS Compliance Plan, and the Eastern Band of Cherokee Indians (EBCI) Personnel Policy. No employee personal account should be used to conduct EBCI PHHS official business or be construed to serve as such.

PROCEDURES:

Accounts:

a. An approved Social Media Justification Form must be on file in the public relations department of PHHS.

viii. Facebook: Public Relations staff must be made Administrators of ALL program Facebook Accounts

ix. For all other Social Media Accounts that do not allow Public Relations staff to be made Administrators account Username and Passwords shall be given to the PR Staff. If account usernames and passwords are changed the PR staff shall be given the updated usernames and passwords immediately

x. Clearly define your objectives

xi. Clearly explain to Administrators/Editors that overtime pay is not given if posting after work hours

xii. Know your target audience

xiii. Determine resource needs

xiv. Determine schedule and frequency posts

APPROVALS:

AUTHORITY:

ATTACHMENTS:

POLICY #: **DAP17 Approval of Divisional Plans and Procedures**

SUBJECT: Approval and enactment of Divisional plans and procedures

PURPOSE: This policy will be used as guidance for timely and inclusive development, approval, and renewal of PHHS Divisional plans and related policies, procedures, and protocols.

DEFINITIONS:

Guideline/ Guidance: A principle or criterion that guides or directs action; often refers to evidence base, best practice, context, or lived experience

Plan: A written process, procedure, and/or protocol that includes operational and logistical details for a given initiative or response by all or part of an organization. Plans may be strategic or tactical, mandatory or optional, internally or externally directed, simple or complex. Examples include: Continuity of Operations Plan (COOP), Facility Emergency Plans, Communications Plan, All-Hazards Plan, Epidemiologic Response Protocols, Strategic Plan [Divisional], Workforce Development Plan)

Policy: A written operational statement of intent; sets out the organization's position and plan in a particular situation; a means of guiding an organization to a desired outcome

Procedure: A written set of instructions that describes how a policy will be implemented; the approved and recommended steps of a particular act or sequence of events in a policy

Protocol: Explicit, specific operational instructions that specify steps to be followed in defined situations under a procedure

POLICY STATEMENT: PHHS maintains multiple Division-wide plans to assure a comprehensive and cohesive process for preparing for and carrying out a variety of initiatives and responding effectively to planned events and unplanned incidents. Divisional plans require collaboration among individuals, programs, and levels of PHHS, as well as coordination with other Tribal entities and, often, external partners. It is necessary to have an established, timely process for review, revision, testing, and assurance that all plans are mutually consistent and align with Divisional strategic priorities.

PROCEDURE/ GUIDELINES:

Origin of plan: A Divisional plan or protocol may originate from Tribal or PHHS leadership or at the program level. It may be assigned, may be a Tribal Government or grant requirement, or may be generated as a quality improvement initiative.

Plan development:

1. PHHS staff assigned to develop plans individually or as a team will obtain initial direction from PHHS leadership (Manager, Director, or Secretary depending on plan level) on plan purpose, requirements, responsible parties, and any special considerations.
2. The planner or plan team will create a timeline for creation or revision, implementation, and evaluation with PHHS leadership.
3. PHHS leadership will assign a primary responsible Director, Manager, or Secretary to monitor plan development and timelines and assure necessary resources are available to planners ("point person").
4. The planner or plan team is responsible for keeping PHHS leadership apprised of the plan's progress on a regular basis.
5. The planner or plan team may consult any internal or external partners as needed and as permissible on contents of the plan.
6. Each plan will reflect Results Based Accountability indicators: how much is being done, how well is it being done, and what is the impact of the plan.
7. Each plan will include:
    a. Title page with PHHS logo, approval date, and version number as applicable
    b. Record of revisions page
    c. Record of approval signatures and dates as applicable
    d. Table of contents with hyperlinks to individual sections
    e. Planned revision cycle dates (usually one year)
    f. Applicable references to other PHHS plans and source documents
    g. Evaluation metrics and process for the plan
    h. List of authorities as applicable
    i. References to source documents and other contributing materials
    j. Attachments and/or appendices as applicable
8. Leadership and plan developers will determine if accompanying Policies and Procedures are necessary and will include them in the document development timeline.

Plan approval:

1. The PHHS leadership primarily responsible for monitoring the planning process—the point person--will assure that the plan is complete by the date determined.

2. Depending on level and type of plan, the point person will bring the final draft plan before the Managers Team, Executive Team, or Secretary for final review within 30 days of completion.
3. PHHS leadership will commit to assuring that a final draft plan is approved and ready for implementation within 60 days of submission.

Plan implementation:

1. PHHS leadership will task teams or individuals to initiate plan implementation immediately upon approval or as designated otherwise.
2. Those responsible for plan implementation will also be responsible for consistent, periodic plan review, evaluation, and testing as applicable. PHHS leadership will assure that reporting of these processes is in place.

Plan evaluation:

1. Evaluation of a given plan will be specific to that plan and will be consistent and timely. Similarly, testing a plan will adhere to a specific schedule and those responsible will report results to appropriate leadership.

AUTHORITY:

ATTACHMENTS:

REFERENCES:

www.compliancebridge.com "The Key Difference Between Policy vs. Procedures" (accessed 10/13/20)

www.bettal.co.uk "Understanding the difference between policies, procedures, protocols, and guidance, PPPGs" (accessed 10/13/20)

POLICY #: DAP18 PHHS Data Sharing Policy

SUBJECT: PHHS Data Sharing Policy

PURPOSE: The purpose of this policy is to ensure that all data sharing requests involving Public Health & Human Services (PHHS) programs and the Cherokee Government are processed consistently and reviewed thoroughly to ensure compliance.

DEFINITIONS:
Data Sharing: The practice of making data used for scholarly research available to other investigators.

Cherokee Government: Is composed of several departments, encompassing a wide range of services functions necessary for the livelihood and welfare of the Cherokee people.

POLICY STATEMENT: Data sharing means sharing personal data to third parties outside of an organization, but it can also cover sharing personal data between different parts of an organization or organizations within the same group or under the same parent company. Specifically, within this policy, data sharing is the sharing of data between PHHS and the various departments of the Cherokee Government.

PROCEDURE/ GUIDELINES: Whenever data is requested to be shared between a PHHS program and a tribal department:

1) A written data sharing request should be submitted by email to the Regulatory & Compliance Department (RCD). The request should be specific and include reasons for requesting the information as well as intentions on how the information will be used.
2) The data sharing request will be reviewed by a compliance officer.
3) The Compliance Officer may review the data sharing request with a corresponding executive team member (Director or Secretary) if necessary or required.
4) Once the data sharing request is either approved or denied, the decision will be submitted electronically to the requesting parties involved.

AUTHORITY:

ATTACHMENTS:

REFERENCES:
Data Sharing |ICO. 9. Data sharing | ICO

EBCI Tribal Government Departments. Departments - Eastern Band of Cherokee (ebci.com)

EMERGENCY PREPARDNESS POLICIES & PROCEDURES

POLICY #: **DEP01 Adverse Weather Emergency Response**

SUBJECT: PHHS Calling Elders During Adverse Weather Events & Other Emergencies

PURPOSE: Define the roles and responsibilities of PHHS staff assigned to call elders in the event of adverse weather, public health emergencies, and/or other events requiring EOC activation.

DEFINITIONS:

Disaster – An occurrence or imminent threat of widespread or severe damage, injury, or loss of life or property resulting from any natural or man-made accidental, military or paramilitary cause.[1]

Response – Activities occur immediately before, during, and directly after an emergency or disaster. They invoke lifesaving actions such as the activation of warning systems, manning the EOC's implementation of shelter or evacuation plans, and search and rescue.

POLICY STATEMENT:

All PHHS staff are required to respond in the event of an emergency if called upon. PHHS employs a variety of personnel in its Public Health & Human Services programs that are qualified to respond in different ways. Those who regularly work with elderly clientele in the community (Tribal In-Home Care, and Family Support) can provide support and resources for this population before, during, and after an emergency situation. This Policy and Procedure addresses the roles and responsibilities of PHHS staff who are directed to call elderly within the PHHS program services area in the event of an emergency.

PHHS staff may be directed by PHHS Administration and/or their Program Manager to staff an emergency calling center, or conduct other aspects of emergency response, as part of their expected job responsibilities. The purpose of the call center is to answer incoming calls to the Public Health 24/7 hotline and to contact the elders served by PHHS. PHHS staff will be covered by Tribal Government essential personnel guidelines for reimbursement for emergency duties and Tribal employee policies including workers' compensation and will receive liability protection through Federal tort law.

PHHS staff will report to the designated site by the Secretary of Public Health or designee and perform duties as assigned. The standard shift length will be 12 hours in a 24-hour operational period, with alterations depending on the emergency. The Incident Commander, PHHS Secretary, or designee will determine duration of assignment. Call center staff will be responsible for reporting periodically to their Program Manager at intervals as determined by the Program Manager.

PROCEDURE/ GUIDELINES:

1. PHHS staff will always maintain a state of personal and professional readiness to respond to emergencies and disasters.
2. EBCI Principal Chief, Emergency Services Director, or designee will notify PHHS Secretary to activate the call center.

3. The Secretary or designee will notify the IT department to set up the call center at PHHS (this location will be determined depending on the situation). Staff without offices will be provided with a space and a phone to use.
4. The Secretary or designee will determine the number of PHHS staff, first resorting to staff in the programs listed above, and assure the staff are notified to report to the call center (Secretary or designee may ask Program Managers to notify staff). Other PHHS staff may be called upon if necessary.
5. Call center staff will be provided with a list of persons to contact and their phone numbers (an updated contact list is kept by Emergency Management).
6. Staff will contact the individuals listed using a script.
7. Staff will keep a detailed log of contacts, time of contact, and notes regarding the phone conversation including any follow up actions needed.
8. If the individual is in immediate need of assistance, notify the appropriate staff person to address this need before continuing to make phone calls.

POLICY #: **DEP02 Emergency Shelters Nursing Staff**

SUBJECT: PHHS Nursing Staff Working in EBCI Emergency Shelters

PURPOSE: Define the roles and responsibilities of PHHS nursing staff assigned to work in emergency shelters opened by Tribal Government

DEFINITIONS:

Disaster - An occurrence or imminent threat of widespread or severe damage, injury, or loss of life or property resulting from any natural or man-made accidental, military or paramilitary cause.
Mass Care - Includes sheltering, feeding operations, emergency first aid, bulk distribution of emergency items, and collecting and providing information on victims to family members.
Nurse - Any licensed full- or part-time Registered Nurse (RN), Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Certified Nursing Assistant (CNA) and Medical Assistant (CMA)
Response - Activities occur immediately before, during, and directly after an emergency or disaster. They invoke lifesaving actions such as the activation of warning systems, manning the EOC's implementation of shelter or evacuation plans, and search and rescue.
Shelter- A facility to house, feed and care for persons evacuated from a risk area for periods of one or more days. For the risk areas the primary shelter and the reception center are usually located in the same facility. (iv)
State of Emergency- A state of emergency shall be deemed to exist whenever during times of public crisis, disaster, rioting, catastrophe or similar public emergency or if for reason, public safety authorities are unable to maintain public order or afford adequate protection for lives, safety or property, or whenever the occurrence of any such condition is imminent. (v)

POLICY STATEMENT:

PHHS employs a variety of licensed nursing personnel in its Public Health programs. These nurses are licensed to perform nursing tasks with the scope of practice dictated by the North Carolina Board of Nursing, the state nurse licensing entity. The nursing scope of practice applies to all work situations for nurses, whether day-to-day or emergency response functions.

This Policy and Procedure addresses the roles and responsibilities of PHHS nursing staff who are directed to staff emergency shelters on the Qualla Boundary.

PHHS nurses may be directed by PHHS Administration and/or their Program Manager to staff EBCI emergency shelters as part of their expected job responsibilities. PHHS nurses who staff these shelters will be covered by Tribal Government essential personnel guidelines for reimbursement for emergency duties and Tribal employee policies including workers' compensation and will receive liability protection through Federal tort law.

PHHS nurses will staff only designated EBCI congregate shelters and will be activated only in a declared State of Emergency by the Principal Chief.

PHHS nurse shelter staff will report to the Shelter Manager and perform only those duties defined by their scope of practice. The standard shift length will be 12 hours in a 24-hour period, with alterations depending on the emergency. The Secretary of Public Health or designee will determine duration of assignment. Nurse shelter staff will be responsible for reporting periodically to their Program Manager at intervals as determined by the Program Manager.

PROCEDURE/ GUIDELINES:

1. PHHS nursing staff, at all times will maintain a state of personal and professional readiness to respond to emergencies and disasters.

2. When notified of a disaster or emergency that necessitates the opening of one or more shelters on the Qua Ila Boundary, Tribal Emergency Management/ 911(Tribal EM) will notify the Secretary of Public Health and Human Services or designee of the location, opening time, and hours of operation of the shelter(s).

3. The Secretary of Public Health and Human Services or designee will determine the number and type of PHHS staff, including nurses, for each shelter, and assure that the staff are notified and activated.

4. Shelter nursing staff will assess symptomatic persons in the shelter at the person's request using an assessment form supplied by shelter management and will work in conjunction with Tribal EMS and emergency personnel. Any person presenting with symptoms that require intervention beyond custodial care will be transported via emergency services to Cherokee Indian Hospital Authority (CIHA) or other local or regional acute care facilities for evaluation and treatment. Assessment of each individual will be based on nursing judgment as defined by the NC Nursing Practice Act.

5. Medication/Treatment Administration: Shelter nursing staff will assist individuals and their caregivers with administration of medication.

6. Training needs for PHHS nursing staff will be recommended by designated shelter management and must be approved by PHHS Administration.

AUTHORITY:

NC Nursing Practice Act: http://www .ncbon.com/myfiles/downloads/nursing -practice-act.pdf (accessed 2/6/15)
Robert T. Stafford Disaster Relief and Emergency Assistance Act, as amended, 42 US Code § 5121 et seq. (2013) https://www.fema.gov/medi a-library/assets/documents/1 5271?fromSearch=fromsearch&id=3564 (accessed 2/6/15)
NC Emergency Management Act (NCGS Chapter 166a) (2012)
http://www . ncga.state. nc.us/gascripts/statutes/StatutesTOC.pl?Chapter =0166A (accessed 2/6/15)

The Cherokee Code,
https://www.municode.com/ library/nc/cherokeeindians eastern band/codes/codeofordinances
(accessed 2/25/15)

REFERENCES:

"Public Health Nurses in shelters," accessed 2/17/15, NC Division of Public Health, personal communication
i EBCI Emergency Operations Plan, 2009, http ://ncempl ans .us/ebci/webver/,accessed 1/30/15
ii FEMA Emergency Support Function #6, Mass Care, http://www.fema. gov/pdf/emergency/nrf/nrf-esf-06.pdf, accessed 1/30/15
iii EBCI EOP, 2009
iv Ibid.
v The Cherokee Code, Ordinance No. 108 (1992)

POLICY #: **DEP03 Continuity of Operations Plan**

SUBJECT: Continuity of Operations Plan

PURPOSE: To establish a policy to ensure the execution of the mission-essential functions of the Public Health and Human Services Division.

DEFINITIONS: COOP – Continuity of Operations Plan

PHHS – Public Health and Human Services

POLICY STATEMENT: In order to ensure that all mission-essential functions are carried out in the event of an emergency, all programs of PHHS will establish a COOP. This COOP will be updated on an annual basis or as necessary based on regulations per program. As a Division, PHHS has a COOP in place and it is reviewed annually.

PROCEDURES: If a program does not have an accrediting body that requires additional language or stricter conditions than the Division-wide COOP policy, then the program is required to put in a policy that it will follow the PHHS Divisional Policy Manual. If a program has an accrediting body that requires additional language or stricter conditions than the Division-wide COOP policy, then the program is required to develop and implement such a policy if they are not less stringent than the conditions of the PHHS COOP policy.

A. The Preparedness coordinator is responsible for the divisional COOP Plan and is stored online at HTTPS://nc.boldplanning.com/. The Secretary of Public Health and Human Services, all PHHS Directors, all PHHS Managers, and all PHHS Regulatory and Compliance Team members have access to the divisional COOP plan. To get access to the divisional COOP located on https://nc.boldplanning.com/ or to receive a copy of the divisional COOP, contact the Preparedness Coordinator. The COOP should be updated on an annual basis and periodically when divisional and/or program changes occur that would affect the Continuity of Operations.

The Preparedness Coordinator will have access to the divisional COOP and each of the program COOPs. The Preparedness Coordinator will provide oversight and ensure that all program COOPs align with the divisional COOP. Each COOP will be created and stored online at https://nc.boldplanning.com/.

APPROVALS:

REPORTING/STATISTICS:

AUTHORITY: EBCI PHHS Executive Committee

ATTACHMENTS:

POLICY #: **DEP04 Essential Supplies and Grocery Assistance**

SUBJECT: Essential Supplies and Grocery Assistance Procedure

PURPOSE: This policy will be used as guidance for the pick-up and delivery of essential supplies and groceries to patients under quarantine orders.

DEFINITIONS: Nonpharmaceutical Interventions (NPI): Actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of illnesses like pandemic influenza (flu). NPIs are also known as community mitigation strategies and are among the best ways of controlling a pandemic when vaccines are not yet available.

POLICY STATEMENT: Public Health programs will provide delivery services for essential supplies and groceries during quarantine status for patients.

PROCEDURE/ GUIDELINES:

Essential supplies and grocery assistance aligns with the Public Health Emergency Preparedness and Response Capability 11-Function 3- Task 2: **Coordinate support services for nonpharmaceutical interventions (NPI).** Assist community partners with coordinating support services, such as medical care, mental health services, and the provision of food and water, for individuals and communities targeted for NPI(s). Assess resource requirements during each operational period and coordinate with partners, including those able to provide mental/behavioral health services for the community, to obtain necessary resources, and to support the medical surge.

Once a patient enters quarantine status, Tsaligi Public Health will perform a virtual/phone wellness check. Patients will be asked if they have any essential supplies or grocery needs that Public Health and Human Services can fulfill. Essential supplies and grocery needs are intended to be for the duration of a patient's quarantine status. Tsaligi Public Health staff will take essential supplies and grocery requests.

Tsaligi Public Health manager will coordinate with the Preparedness Coordinator to deploy the Assistance Team. Assistance requests after 3:00 pm will be completed the following day unless it is deemed an urgent need.

The Assistance Team includes the following Public Health and Human Services programs listed below:

- Tsaligi Public Health
- Emergency Preparedness
- Syringe Services Program
- Cherokee Choices
- Children's Dental
- Regulatory and Compliance

Other programs may be recruited if the Assistance Team is understaffed or overwhelmed with requests.

It is understood that the Assistance Team is "on-call" and may have to pause or reschedule routine work roles and functions to fulfill essential supplies and grocery requests.

Snowbird and Cherokee County Services will be responsible for fulfilling any essential supplies and grocery requests within that service area. . This will be coordinated between Tsaligi Public Health and the Director of Services.

The Preparedness Coordinator will request a credit card and Tribal vehicle for the Assistance Team to use to fulfill requests. The Assistance Team will pick these items up from the PHHS Executive Assistant or other designated personnel and be returned once requests are complete. Staff with PIN numbers for gas/WEX cards should fill up the Tribal vehicle before returning the car.

The Assistance Team will shop based on the grocery list provided and maintain financial stewardship. More than one delivery may be required at a time, have a receipt for each patient request. Receipts must be saved and turned in to PHHS Executive Assistant or designated personnel.

Requests for pet supplies and food with little nutritional value will not be fulfilled by the Grocery Team. If patients have questions about their request, they can contact Tsaligi Public Health.

The Assistance Team should call patients ahead of time to let them know an estimated delivery time. Delivery is contactless. When speaking with patients, ask where the essential supplies and groceries should be placed (e.g. porch) and remind them to not retrieve items until the Assistance Team has left. It is also recommended that the Assistance Team ask patients to confine any pets or animals so that the delivery is not disturbed.

If the Assistance Team feels unsafe or threatened, do not continue with delivery. Return to work and contact the Preparedness Coordinator (828) 359-1500 or (336) 776-7911. If there is an emergency, call 911.

The Assistance Team should notify the Preparedness Coordinator when departing to and from and patient's home and upon return to the PHHS campus.
Personal protective equipment (PPE) is recommended as well as other safety precautions (use of hand sanitizer, etc). If PPE or other safety supplies are needed, contact the Preparedness Coordinator.

AUTHORITY:

ATTACHMENTS:

POLICY #: **DEP05 24/7 Contact and Services Policy**

SUBJECT: 24/7 Contact and Services

PURPOSE: In an emergency incident partners and members of the public requiring assistance must have access to normal business hours and after-hours contact information for PHHS programs and leadership to promote rapid and effective response.

DEFINITIONS:

POLICY STATEMENT: The Eastern Band of Cherokee Indians Public Health and Human Services Division maintains a system to receive and provide health alerts and public health response for healthcare providers, emergency responders, and communities on a 24-hour-a-day, 7-day-a-week basis.

PROCEDURES:

PHHS Public Relations and Preparedness will assure that phone numbers for Public Health business hours and after-hours will be available on the main voice message line and be displayed on the PHHS webpage for individual programs.

During normal business hours, the EBCI PHHS main phone line and individual program phone lines will be available for everyday incidents and emergencies. The EBCI PHHS main phone line is 828-359-6180 which operates Monday through Friday from 7:45 am - 4:30 pm.

For after-hours contact and services, an after-hours message will direct callers to 828-359-1500 for public health emergencies only and to call 9-1-1 for life-threatening events. This is a cell phone maintained by the Preparedness Coordinator or designated staff for 24/7 contact and services. The following reception staff in succession will be responsible for switching the phone over for after-hours, weekends, and holiday or administrative leave:

- PHHS Administrative Assistant
- Public Health/ Operation's Director's Administrative Assistant
- Public Relations Assistant.

The phone lines will be switched and operational:

- During after-hours, Monday through Thursday from 4:30 pm- 7:45 am
- On weekends, Friday at 4:30 pm through Monday at 7:45 am
- On holidays and administrative leave from the time holiday/administrative leave begins until EBCI PHHS opening time the next business day.

The Preparedness Coordinator will do the following, or designate the following roles and responsibilities to the appropriate staff:

- Provide the script for the after-hours message to the PHHS Administrative Assistances
- Keep and maintain the after-hours cell phone and assure that it remains operational at all times
- Maintain a schedule of after-hours staff to carry and answer the cell phone (if a schedule is needed)
- Maintain a log of all after-hours Public Health-related calls
- Annually review and revise the 24/7 Contact and Services policy.

If the Preparedness Coordinator is out of office, the after-hours contact line will be the responsibility of the Operations Director or designee. This will be coordinated, and the after-hours contact, and services line will be exercised with the designee before their duty.

EBCI PHHS is committed to responding to after-hour emergency calls in a timely manner. The on-duty staff is required to respond to or refer callers within 3 hours of being contacted; there is some flexibility in response time if contacted during early morning hours. Any concerns about response time will be reviewed by the PHHS Secretary or Health Director.

Back-up communication modalities include:

- Contacting 9-1-1 in life-threatening emergencies
- Contacting program hotlines, i.e. Domestic Violence (828-359-6830)
- Contacting Tribal programs (see table below)
- Contacting the program via email, this may result in a longer response time.

The 24/7 Contact and Services line will be tested quarterly, and an After Action Report/Improvement Plan (AAR/IP) will be prepared by the Preparedness Coordinator after each test.

APPROVALS:

REPORTING/STATISTICS:

AUTHORITY: EBCI PHHS Executive Committee

ATTACHMENTS: 24/7 Contact and Services Voice Message script; 24/7 Public Health Emergency Contact List

SCRIPT

Siyo, you have reached the Public Health and Human Services Division of the Eastern Band of Cherokee Indians. If this is a life-threatening emergency, please hang up and dial 9-1-1. If you need to report a Public Health emergency, please hang up and dial 828-359-1500 to reach the employee on-call. If you want to leave a detailed message, your call will be returned on the next business day. Thank you and have a great day.

M-Th
Preparedness/designee turns on phone @ 4:30pm and phone remains operational until 7:45am the following morning.

Weekends
Preparedness Coordinator/designee is available through after-hours phone beginning Fridays at 4:30pm and remains operational until Monday at 7:45am.

Holidays/Administrative Leave
Preparedness Coordinator/designee is available via emergency phone when holiday and administrative leave begins. The phone remains operational until 7:45am on the next business day.

Preparedness Coordinator/designee answers phone promptly.

Preparedness Coordinator/designee handles/ responds to emergency.

Preparedness Coordinator/designee refers caller to appropriate program supervisor/manager.

Preparedness Coordinator/designee notifies PHHS Secretary and Health Director of emergency.

Caller contacts referral entity directly.

Preparedness Coordinator/designee records call and any follow-up measures in call log.

24/7 Public Health Emergency Contact List

The Emergency Contact List will be made available to staff and programs for after-hour reporting.

ANIMAL CONTROL		
Shane Davis	Primary Animal Control Supervisor	Office: 828-497-6091 Cell: 828-736-0568

EBCI Animal Control is located at 42 Lee Taylor Road, Cherokee, North Carolina 28719. For after-hours assistance, contact Tribal Dispatch as 828-554-6168.

CDOT		
Manuel Maples Joey Owle	Primary Director of Infrastructure and Public Facilities Secondary Construction Supervisor	828-788-1717 828-508-2869 Roadway Issues: 828-359-6530/ 828-359-6532 Home Driveway: Issues 828-359-6841

CHEROKEE FIRE AND RESCUE		
Curtis Arneach	Primary Fire Chief	Office: 828-359-6150 Cell: 828-

COMMUNICABLE DISEASE		
Ginger Southard	Primary Nursing Director	Office: 828-359-6879 Cell: 828- 736-5069
Stella Blankenship	Back-up CD Nurse	Office: 828-359-6241

DOMESTIC VIOLENCE		
Marsha Jackson	Primary Program Manager	Office: 828-359-6829 Cell: 828-736-4296 Hot line 24/7: 828-359-6830

CIHA EMERGENCY ROOM	
	Office: 828-497-9163

[redacted]	Press 6 then press 4.

ENVIRONMENTAL HEALTH		
Dwayne Reed	Primary Environmental Health & Safety Manager	Office: 828-359-6249 Cell: 828-788-5861

EBCI Environmental Health has an MOA with jurisdictional counties who may manage the incident. The Environmental Health & Safety Manager will coordinate this if needed.

FAMILY SAFETY		
Sasha Jumper	Primary Program Manager	Office: 828-359-1554 Cell:828-788-5451

PUBLIC HEALTH EMERGENCIES/THREATS		
Lyndsey Henderson	Primary Preparedness Coordinator	Office: 828-359-1500 Cell: 336-776-7911
Aneva Hagberg	Secondary Operations Director	Office: 828-359-6169 Cell: 828-736-0275

PUBLIC SAFETY COMMUNICATION CENTER	
The center of communication for E911, Police, Fire, EMS, NRE, and Emergency Management Services.	
[redacted]	Main: 828-359-6444

TRAINING POLICIES AND PROCEDURES

POLICY #: **DTP01 NIMS | ICS Training**

SUBJECT: National Incident Management System (NIMS) and Incident Command System (ICS) Training

PURPOSE: All PHHS staff are responsible for public health emergency response within the scope of their position, certification or licensing. Responsibilities vary between programs and staff positions. This policy mandates basic ICS and NIMS training for PHHS staff.

DEFINITIONS:

Incident Command System (ICS): "A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations." (FEMA)

National Incident Management System (NIMS): "A system mandated by HSPD-5 that provides a consistent nationwide approach for Federal, State, local, and tribal governments; the private sector; and nongovernmental organizations to work effectively and efficiently together to prepare for, respond to, and recover from domestic incidents, regardless of cause, size, or complexity. To provide for interoperability and compatibility among Federal, State, local, and tribal capabilities, the NIMS includes a core set of concepts, principles, and terminology. HSPD-5 identifies these as the ICS; multiagency coordination systems; training; identification and management of resources (including systems for classifying types of resources); qualification and certification; and the collection, tracking, and reporting of incident information and incident resources." (FEMA)

Preparedness Coordinator (PC): PHHS staff member responsible for development and maintenance of PHHS emergency response plans including but not limited to PHHS All-Hazards Plan, Continuity of Operations Plan (COOP), Pandemic Response Plan, Isolation and Quarantine Plan, Respiratory Protection Plan, NIMS and ICS Training Plan, and Medical Countermeasures (MCM) Dispensing plan.

POLICY STATEMENT:

1. The PHHS Preparedness Coordinator (PC), in consultation with PHHS Administration, shall establish and maintain the ICS and NIMS Training Policy and Procedures for PHHS.
2. The PHHS Preparedness Coordinator shall review any applicable Tribal, state and federal regulations, directives, rules, or other administrative or legislative orders pertaining to NIMS and ICS training, and shall inform PHHS Administration of any such changes that may necessitate

updates to the PHHS ICS and NIMS Training Policy and Procedures. The PC shall propose any needed changes and update Policy and Procedures for approval by PHHS Administration.

3. The PC, as directed by the Secretary of PHHS or designee, in collaboration with the PHHS Training Coordinator, shall monitor and assure required NIMS and ICS training for all PHHS staff according to the scope of their responsibilities, within a fixed time after an employee's hire date or change of position.
4. The PC, with approval by the Secretary, shall establish and maintain NIMS and ICS training procedures.
5. The PC shall maintain a copy of all applicable valid and current NIMS and ICS training records, files and/or certificates for each PHHS employee.
    a. Records of NIMS and ICS mandatory course completions will be kept in the PHHS training database. Each employee will be responsible for maintaining his/her NIMS and ICS certificates as personal copies and/or in his/her program
    b. personnel files, and for reporting his/her course completions to his/her Program Manager.
    c. The PC may purge NIMS and ICS training records, files and certificates if:
        i. The employee is no longer employed by PHHS for a period greater than 6 months; or
        ii. The training record, file or certificate is expired.
6. All PHHS employees are required to attend and pass NIMS and ICS training in the time prescribed by this policy and procedure at no cost to them. Employees will not be penalized for not completing classes within the prescribed time if none are offered during that time, or if they offer an excusable reason that is approved by the PC or Secretary or designee.
7. The PC and/or Secretary or designee shall review this policy and make any necessary changes annually.

PROCEDURE/ GUIDELINES:

1. All newly hired staff or staff members who have changed positions within Tribal Government shall review the PHHS NIMS and ICS Training Policy and Procedure during the first ninety days of their employment in PHHS.
2. The PC will be available to any new staff to answer questions about NIMS, ICS, and emergency response roles and responsibilities.
3. The PC will use NIMS training guidelines as established by FEMA's National Integration Center (NIC) to determine the level and extent of training needed for staff members according to their roles in emergency functions.
4. Mandatory basic NIMS and ICS training for all PHHS staff is:
    a. IS 100a or IS 100HCb
    b. IS 200a or IS 200 HCa

c. IS 700a

These courses are online, self-paced individual courses and are accessible at any time at http://training.fema.gov/IS/NIMS.asp. Staff may take them at work or at home but will not receive payment or compensatory time for taking the classes outside work hours.

5. All PHHS staff shall complete these courses within 90 days of hire or position change and shall deliver a paper or electronic copy of the course certificate of completion to his or her Program Manager or designee.
6. The Training Coordinator or designee shall maintain a list of all PHHS staff's NIMS and ICS completion data including employee name, course name(s), and dates of completion and give this information without delay to the PC on request.
7. At least two PHHS Administration staff at any given time shall have taken the following ICS classes:
   a. ICS 300
   b. ICS 400
   c. ICS 800b

   ICS 300 and 400 are delivered in a classroom setting at no cost to the employee. IS 800b is offered online at http://training.fema.gov/IS/NIMS.asp. Upon completion of each course, the employee shall present the certificate of course completion to the PC for entry into the PHHS training database. If the employee is unable to attend class for an excusable reason, the PC will assist him/her in finding the next available class. New hires or those changing position into PHHS Administration shall complete IS 800b, ICS 300 and 400 within 9 months of hire or position change.
8. The PC and Secretary of PHHS or designee shall determine the need for additional NIMS and/or ICS training for PHHS employees with specific responsibilities (such as Safety, Public Information or positions in the Emergency Operations Center [EOC]) and shall require or recommend those additional trainings as approved by the Secretary of PHHS or designee. The employee shall complete the required training(s) within six months of notification by the PC or Secretary of the need to do so. Upon completion of the course, the employee shall present the certificate of course completion to his/her Program Manager, who shall in turn deliver a copy to the PC.
9. The PC shall forward an updated copy of this Policy and Procedure to EBCI Emergency Management within 30 days of approval and signing by the Secretary or designee.

AUTHORITY: "National Incident Management System Training Program September 2011," US DHHS

"NIMS Training Requirements 2011," North Carolina Division of Public Health

ATTACHMENTS: None

POLICY #: **DTP02 Cardiopulmonary Resuscitation CPR**

SUBJECT: Cardiopulmonary Resuscitation Training (CPR**)**

PURPOSE: To establish guidelines and requirements for receiving and maintaining CPR Certification

POLICY: It will be the policy of the Public Health & Human Services that all employees are trained to intervene in crisis situations that require the use of basic CPR. Employees are expected to be able to identify a medical emergency and take immediate and appropriate measures, as outlined in the policy, to address such emergencies within the scope of practice.

PROCEDURE:

1. Within the first ninety (90) days of employment attempts will be made to have staff certified in CPR.
2. No direct patient care staff will be assigned to work alone at any Public Health & Human Service Program locations without another member who is current in CPR.
3. CPR training courses will be scheduled division-wide by the Public Health & Human Services Training Coordinator. Clinical Programs will have the option of completing CPR training within their programs by a certified CPR instructor.
4. Staff who do not attend training offered by the Training Coordinator or by an in-house certified instructor will be responsible for payment of the training.

AUTHORITY:

ATTACHMENTS:

REFERENCES:

POLICY #: **DTP03 First Aid Training**

SUBJECT: First Aid Training

PURPOSE: To establish guidelines and requirements for receiving and maintaining First Aid

DEFINITIONS: N/A

POLICY: It is the policy of the Cherokee Public Health & Human Services that all employees are trained to intervene in crisis situations that require employee's dissemination of First Aid. Employees are expected to be able to identify a medical emergency and take immediate and appropriate measures, as outlined in the policy, to address such emergencies.

PROCEDURE:

1. Within the first ninety (90) days of employment attempts will be made to have staff certified in basic First Aid.
2. No direct patient care staff will be assigned to work alone at any Cherokee Public Health & Human Services Division Program locations without another staff member who is current in First Aid.
3. First Aid Training will be scheduled division wide by the Cherokee Public Health & Human Services Training Coordinator. Some clinical programs may have the option of completing First Aid by an in-house certified First Aid instructor.
4. Staff who do not attend training offered by the Training Coordinator or a clinical in-house certified instructor will be responsible for payment of the training.

AUTHORITY:

ATTACHMENTS:

REFERENCES:

POLICY #: **DTP04 Respiratory Protection Training and Fit-Testing**

SUBJECT: Respiratory Protection Training and Fit-Testing

PURPOSE: To establish guidelines and requirements for Respiratory Protection training and respirator fit testing.

POLICY: It will be the policy of the Public Health and Human Services Division to maintain a Respiratory Protection Program to protect staff who may be exposed to respiratory pathogens that require respiratory protection over and above the level of social distancing and/or surgical masks.

PROCEDURES:

Level of protection: The PHHS Respiratory Protection Program will cover the use of N-95 respirators. No other types of respirators (P, R, facemask, self-contained breathing apparatus, etc.) will be used.

Program Administration: PHHS Administration will designate a Respiratory Protection Program Administrator, who will:

- Identify work areas, processes, or tasks that require workers to don respirators.
- Evaluate hazards.
- Select appropriate respiratory protection.
- Monitor respirator use to ensure that respirators are used in accordance with their certification.
- Arrange for and /or conduct training.
- Ensure proper storage and maintenance of respiratory protection equipment.
- Administer the medical surveillance program.
- Maintain records required by the program.
- Evaluate the program for compliance.
- Update the written program as needed.

Hazard evaluation and respirator use: The Respiratory Protection Program Administrator will report to PHHS Administration any new or changed hazards, work areas, processes, or tasks that require changes in Respiratory Protection policies and procedures as soon as practicable and will make recommendations for changes in the Respiratory Protection Program, policies and/or procedures, including types of respirators. PHHS Administration will be responsible for approving these recommendations and assuring that they are carried out. The Respiratory Protection Program Administrator will also assess staff respirator use in the event it is necessary by spot check, review, or other method as s/he deems appropriate, and may require any employee to revise his/her respirator use, including to repeat training, if deemed necessary by the Respiratory Protection Program Administrator.

Medical evaluation and approval: PHHS will coordinate medical evaluations and medical approval for respirator fit testing with the Immediate Care Center, and the Respiratory Protection Program Administrator will be responsible for coordinating questionnaire completion, medical evaluation appointments, confidential maintenance of employee questionnaires in compliance with HIPAA, and maintenance of medical approval forms.

Identification of eligible employees: PHHS Division Directors and/or the Secretary of PHHS or designee will identify all employees who are required to wear respirators during certain times in the course of their work; will maintain records of these employees within their Program; and will assure that these employees maintain compliance with mandatory annual OSHA (Occupational Safety and Health Agency) Respiratory Protection training and respirator fitting (fit-testing).

Restriction of job duties for staff not current with Respiratory Protection training and fit-testing: Employees who are not current with fit-testing and training requirements will not be permitted to carry out job duties that expose them to respiratory hazards identified in a specified location and time period by the Respiratory Protection Program Administrator. They will be reassigned to job duties that do not carry risk of, or carry decreased risk of, exposure to a respiratory hazard or, if such duties are not available, will not be allowed to work in their current position for the duration of the exposure. In certain emergent circumstances, with the approval and at the discretion of the Secretary and the Respiratory Protection Program Administrator, staff who are eligible for fit-testing but are not current with training or fit-testing may undergo "just-in-time" training and fit-testing to enable them to perform necessary job duties. This will be considered only if time, personnel, equipment and supplies are available to perform the training and fit testing.

Program maintenance and evaluation: The Respiratory Protection Program Administrator will be responsible for maintenance of all Respiratory Protection Program records except for approved staff by Program, which will be maintained by each Program Manager and which will be available on request to the Respiratory Protection Program Administrator. The Respiratory Protection Program Administrator will be responsible for assuring adequate inventory and storage of ResProt equipment and supplies and for periodic program review and updates, at minimum annually, to assure applicability to PHHS and compliance with Tribal Risk Management policies and procedures.

ATTACHMENTS:

- Respiratory Protection Plan
    - Medical Evaluation Form
    - Approval Form
    - Fit-Testing Procedure

AUTHORITY:

REFERENCES:

POLICY #: **DTP05 Bloodborne Pathogen Training**

SUBJECT: Bloodborne Pathogen Training

PURPOSE: To reduce the risk of occupational exposure to bloodborne pathogens, and/or other potentially infectious materials in work environments.

DEFINITIONS:

Bloodborne Pathogens:	Pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, Hepatitis B Virus (HBV) and Human Immunodeficiency Virus (HIV). Other potentially infectious materials include the following human body fluids: semen, vaginal fluid, saliva in dental procedures, and anybody fluid that is visibly contaminated with blood.
Occupational Exposure:	Actual, or potential, parental, skin, eye, or mucous membrane contact with blood; or other potentially infectious materials that may result from the performance of an employee's duties.

POLICY STATEMENT: It is policy of the Public Health & Human Services that all employees are trained to identify occupational exposure to bloodborne pathogens and/or other potentially infectious materials. Employees are expected to be able to identify the potential risk of occupational exposure, how/ when to use proper personal protection equipment, and gain general knowledge of decontamination.

PROCEDURE/ GUIDELINES:

1. Within (90) days of employment attempts will be made to have staff trained in Bloodborne Pathogen.

2. Bloodborne pathogen training will be scheduled division wide by the Public Health & Human Services Training Coordinator. Some PHHS programs may have the option of completing Bloodborne Pathogen training in-house. Employees are required to send a Certificate of Completion to the training Coordinator for documentation.
3. Staff member are responsible to attend bloodborne pathogen annually during open training dates/times.

AUTHORITY:

ATTACHMENTS:

POLICY #: DTP06 HIPAA/PRIVACY & SECURITY/CONFIDENTIALITY TRAINING

SUBJECT: Health Insurance Portability & Accountability Act (HIPAA)/ Privacy & Security & Confidentiality Training

PURPOSE: To establish guidelines and requirements for HIPAA/ Confidentiality training.

DEFINATIONS:

POLICY STATEMENT: It will be the policy of the Public Health and Human Services Division that all employees complete HIPAA & Confidentiality training.

PROCEDURE/ GUIDELINES:

1. Within (15) days of employment, all new employees are to have HIPAA Privacy & Security/Confidentiality training.

2. If circumstances arise and the new employee does not complete the HIPAA Privacy and Security Training within the first 15 days of employment, the Training Coordinator will contact the new employee's immediate director/ manager/ supervisor to coordinate a date/time to complete.

3. HIPAA Privacy & Security/ Confidentiality training will be scheduled division wide during every orientation and annually by the Public Health & Human Services Training Coordinator.

4. Staff members are responsible for attending the HIPAA Privacy & Security/ Confidentiality training annually during open training dates/times. Training Coordinator will provide make-up training dates to ensure all employees complete training.

AUTHORITY:

ATTACHMENTS:

POLICY #: **DTP07 Compliance Plan Training**

SUBJECT: Compliance Plan Training

PURPOSE: To establish guidelines and requirements for receiving Compliance Plan Training and to educate employees on compliance regulations to reduce divisional risk.

DEFINITIONS:

POLICY STATEMENT: It will be the policy of the Public Health & Human Services that all employees are trained on the Public Health & Human Services Compliance Plan.

PROCEDURE/ GUIDELINES:

1. Within (15) days of employment all new employees are to have Compliance Plan training
2. If circumstances arise and the new employee does not complete the HIPAA Privacy and Security Training within the first 15 days of employment, the Training Coordinator will contact the new employee's immediate director/ manager/ supervisor to coordinate a date/time to complete.
3. Compliance Plan training will be scheduled division wide during every orientation and annually by the Public Health & Human Services Training Coordinator.
3. Staff members are responsible for attending the Compliance Plan training annually during open training dates/times. Training Coordinator will provide make-up training dates to ensure all employees complete training.

AUTHORITY:

ATTACHMENTS:

REFERENCES:

SAFETY POLICY AND PROCEDURES

POLICY #: **DSP01 Divisional Flu & TB Policy**

SUBJECT: Divisional Flu & TB Policy

PURPOSE: To assure all PHHS employees have access to routine screening and immunizations.

STAFF GOVERNED BY THIS POLICY: All Divisional Employees

DEFINITIONS: Please provide definitions for policy (flu, tuberculosis etc.)

POLICY STATEMENT: Tsa-La-Gi Public Health provides minimal Employee Health management for PHHS divisional employees.

PROCEDURE/ GUIDELINES: Designated CHN will provide flu shots to all PHHS employees when the vaccine becomes available each year. PHHS employees who do not want the influenza vaccine must sign a refusal letter. New employees are required to provide tuberculin testing that occurred within the previous six months. If no test is available, the designated CHN will secure PPD to administer to the employee. In February of each fiscal year all PHHS employees will receive a questionnaire to complete regarding TB testing. Employees who have risk factors as defined by the TB policy will be administered PPD. Employees with no risk factors will complete the questionnaire only.

AUTHORITY: notate policies, laws, regulations etc. that back up this policy

ATTACHMENTS:

REGULATORY & COMPLIANCE

POLICY #: **DRC01 Incident Report Process**

SUBJECT: Incident Report Process for all Public Health and Human Service (PHHS} Programs

PURPOSE: To ensure that all incidents involving suspected abuse, neglect, or that require medical care be provided outside of the respective PHHS Program where incident occurred are reported to a PHHS Compliance Officer for thorough investigation (if needed} and that a standardized investigation process, communication flow between the PHHS Program Staff, Program Manager, Director, Compliance Officer(s} and the EBCI Risk Management Department occurs as required.

DEFINITIONS: N/A

POLICY STATEMENT: All reports that document incident's which occur to a customer while receiving PHHS Program services involving medical treatment from an outside source, or an incident of suspected abuse or neglect of a customer while they were receiving services, shall be sent to a PHHS Compliance Officer within twenty-four (24) hours' of the incident's occurrence using the attached standardized incident reporting form OR the Program's individualized incident reporting form. The receiving PHHS Compliance Officer shall immediately make a copy for PHHS records and deliver the original incident report to the EBCI Risk Management Department staff. Risk Management and PHHS Compliance will collaborate on all required investigations. A copy of the incident report will be linked to the Secretary of PHHS, and associated Director, and the manager of the PHHS program involved. When an investigation is warranted, it will be initiated no later than three (3) business days of the receipt of the incident report by a PHHS Compliance Officer.

Note: If the full incident report cannot be completed within the required 24-hour reporting timeframe, the staff and/or Program Manager may contact a PHHS Compliance Officer via phone or email and provide all the information available to that time. The PHHS compliance officer may complete the EBCI incident report with the available information and deliver the original to Risk Management notifying them that more information regarding the incident will be forth coming.

PROCEDURE/ GUIDELINES: When an accident and/or injury occurs at a PHHS Program to a customer of services and requires “out of service” treatment, an incident report form is to be completed by program staff or their supervisor. If the individuals involved in the incident experienced an injury requiring medical treatment outside of the PHHS program or if abuse or neglect by another individual is suspected, the PHHS Compliance Officer will collaborate with the EBCI Risk Management Department staff to complete all needed investigations. These reports may include the following:

1. Lost or missing child or vulnerable adult;
2. Suspected maltreatment of a child or vulnerable adult;
3. Suspected sexual, physical, or emotional abuse of staff, volunteers, or family members occurring while they are on the premises of the program;
4. Injuries to the individuals requiring medical or dental care outside of services provided by the program;
5. Severe mental health emergencies;
6. Health and safety emergencies involving parents/guardians and visitors to the PHHS program;
7. Death of an individual. Including a death that was the result of serious illness or injury that occurred on the premises of the PHHS program or due to an event that occurred while the individual was on the PHHS program premises;
8. The presence of a threatening individual who attempts or succeeds in gaining entrance to the PHHS program facility;
9. Or any other incident of significance.

The PHHS Compliance Officer shall file a report of suspected abuse or neglect of a customer to a Family Safety Intake Worker if it has not already been reported by the manager of the program where the incident occurred. If there is possible criminal conduct involved, the PHHS Compliance officer shall contact the Cherokee Police Department if it has not already been reported by the manager of the program where the incident occurred.

> *Note: Customers of PHHS Program services are on premises when in facilities, outside any facilities, in the parking lot, or in program specific transportation buses or vehicles.*

All findings from investigations completed by a PHHS Compliance Officer regarding an incident, will be submitted to the EBCI Risk Management Department, the Secretary of PHHS, associated director, and the manager of the PHHS program involved.

RISK MANAGEMENT AUTHORITY POLICY: To establish policies and procedures related to the risk management functions of the Eastern Band of Cherokee Indians including the administration of the tribe's insurance policies, employee safety, and risk assessment, monitoring, reporting, and mitigation.

ACCIDENTS/INJURIES TO VISITORS AND GUEST: When a visitor or guest is involved in an accident or is injured while on premises of a tribal government facility, seek medical attention for the visitor or guest as required, immediately notify a supervisor and supervisors, should immediately notify Risk Management of the accident or injury. The reporting process will be like that of reporting an employee accident or injury. Supervisors shall use all standard reporting forms as required by Risk Management.

SUPERVISOR'S SAFETY GUIDE-GENERAL: Investigate, analyze, and report every accident no matter how slight. All accidents/incidents are to be reported to your supervisor immediately. The supervisor will

immediately report it to the manager and Risk Management. Accident/incident reports are to be submitted to Risk Management within 24-hours of the event.

ACCIDENT INVESTIGATION-GENERAL: Accident investigation and analysis is one means used to prevent or reduce future accidents. This section outlines accident and loss investigation procedures. The first report of an on-the-job accident/injury or loss shall be prepared and forwarded to Risk Management within 24 hours as specified by our policies and procedures. All accidents/incidents shall be notified on the event and the workplace safety officer will also investigate. Recommendations may be provided to prevent this from occurring again.

AUTHORITY:

ATTACHMENTS:

POLICY #: **DRC02 Records Retention**

SUBJECT: Retaining and destroying records

PURPOSE: Define the guidelines for retaining or destroying records.

DEFINITIONS: N/A

POLICY STATEMENT: The Public Health & Human Services Division recognizes the need for orderly management and retrieval of all official records and a documented records retention and destruction schedule congruent with all tribal laws and related regulations. All official records (paper, electronic, or any other media) will be retained for the minimum periods stated in Public Health & Human Services Division's (PHHS) *Records Retention Schedule.* After a specified time period, official records must be disposed of in a manner that is consistent with, and systematically carried out in accordance with, prescribed records and information management guidelines and procedures.

All original visits generated by Women's Wellness, Qualla Youth Health Center, Cherokee County Clinic, and Cherokee Diabetes Clinic will be sent to Cherokee Indian Hospital Authority for placement in the patient's medical record file. These original documents will be held at the facility for three to seven years and then transferred to the appropriate Federal Records Center. In accordance with the records disposition authority approved by the Archivist of the United States, paper records are maintained for 75 years after the last episode of individual care except for billing records.

PROCEDURE/ GUIDELINES:

Duplicate files, duplicate copies, library materials, and stocks of obsolete forms or pamphlets originally intended for distribution are not considered to be official records or record copies. Duplicates or non-record convenience copies should be destroyed when they cease to be useful and should never be kept longer than the official record copy.

The *Records Retention Schedule* provides a list of official records for each program, and prescribes the periods of authorized retention and assists the Public Health and Human Services Division in:

1. complying with legal requirements;
2. destroying records that no longer have value to the (PHHS);
3. providing legal protection to PHHS Division when destroying records;
4. retaining records of permanent value;
5. improving protection of vital records;
6. providing security for records with confidential or sensitive information;
7. using office space for access to active records;
8. moving inactive records into less expensive storage areas;
9. releasing equipment and reusable media for other productive uses; and,
10. maintaining records in the formats offering optimum cost effectiveness.

RECORD RETENTION SCHEDULE

The records retention schedule is developed from data collected during a records inventory. The *Records Retention Schedule* may be revised periodically to include a newly created record series, to change retention periods, or to delete a record series no longer useful. Appropriate approval procedures must be followed and completed before any revisions would become effective.

All records are to be kept for the minimum periods listed in the *Records Retention Schedule*. Notwithstanding such minimum retention periods, all records must be maintained until all required audits are completed and should be retained beyond the listed retention periods when there is a probability of litigation either involving records or requiring their use.

Official records kept only in electronic format must be identified in the *Records Retention Schedule* and must comply with the tribal rules.

Vital records should be identified in the *Records Retention Schedule* and protected in accordance with tribal law.

See attached Record Retention Schedule.

RECORDS INVENTORY

A records inventory identifies records, where they are located, and in what quantity. All records should be inventoried, regardless of the media in which they are maintained. **A Records Inventory Worksheet** is used for inventorying records and must be prepared each time a records series is created.

A records series is a group of identical or related records that are normally used and/or filed together, and that permit evaluation as a group for retention scheduling purposes. For example, a purchasing department may have eight file cabinets full of purchase order and requisition records that are filed by fiscal year. The chronological arrangement of the files is for the purpose of making access to the records easier. Each fiscal year is not a separate records series; the entire group of files is one records series because they all document the same activity and have the same retention period. Therefore, only one inventory form would be completed for all the records in these eight file cabinets.

DESTRUCTION OF RECORDS

No records may be destroyed without permission from the Compliance Officer. The EBCI has two established methods for obtaining legal authority to destroy tribal records. Procedures differ for records listed on an approved *Records Retention Schedule* and any records not listed.

A tribal record may not be destroyed if any litigation, claim, negotiation, audit, open records request, administrative review, or other action involving the record is initiated before the expiration of the retention period for the record set in the approved institutional *Records Retention Schedule*.

If no action as described above has been taken, records may be destroyed in accordance with the approved retention periods shown in the *Records Retention Schedule*. Prior to disposal of official records, all tribal records policies must be followed.

Tribal records not listed on the approved *Records Retention Schedule* may be destroyed after receiving approval by submitting a **request** to the Compliance Officer. (see below request)

Ultimately, programs are responsible for providing support documentation in the event of any litigation, claim, negotiation, audit, open records request, administrative review, or action involving a record. The confidentiality of protected health information will be protected up until the final point of destruction.

Public Health & Human Services Division

Records Retention Schedule

Name	Legal Citation	Total Retention
Medical Research Records Institutional Review Board Research Records	45 CFR 46.115	3 years After completion of the Research
Health Records Patient Medical Records-Adults	10 N.C.A.C. 3C.3903(a)	Adults-11 years following discharge
Health Records Patient Medical Records-Minors	10 N.C.A.C. 3C.3903(b)	Until the 30th Birthday
Health Records Psychiatric Records-Adults	10 N.C.A.C. 3C.3903(a)	Adults-11 years following discharge
Health Records Psychiatric Records-Minors	10 N.C.A.C. 3C.3903(b)	Until the 30th birthday
Patient Account Services Insurance Claims		Current year plus 6 years
Clinic Records Appointment Books		3 years
Clinic Records Social Service Confidential Case Histories- adults	10 N.C.A.C. 3C.3903(a)	Adults -11 years following discharge
Clinic Records Social Services Confidential Case Histories-minors	10 N.C.A.C. 3C.3903(b)	Minors-until 30th birthday
Nursing Records Visit Notes.		3 years. Notes concerning patients, which do not become part of the patient medical record
Pharmacy Records	NCAC	5 years including Radioactive Drugs. 10 years for Medicare Part D records.
Home Health Records		7 years from discharge
	10A NCAC	5 years following discharge; Minors if

Skilled Nursing Facilities	13D. 2402 (1996)	discharged keep on file until patients 19th birthday and then for 5 additional years.
Maternal Health/Baby Love DHHS-Record Retention Policy-	local health departments	Adult pts: destroy in office 10 years from date of last service. Pediatric pts: destroy in office when individual reaches 28 years of age.
SHIP		7 years from the date of service.
EMS Records/Runs		7 years from the date of service run.
Medical Compliance Documents and Investigations		7 years

(This retention schedule follows NC Law on Record Retention.)

**Fiscal records will be kept for seven (7) years following the date of payment or final denial of payment for services provided.

AUTHORITY:

ATTACHMENTS: None

POLICY #: **DRC03 Conflict of Interest**

SUBJECT: Conflict of Interest Policy

PURPOSE: The purpose of this policy is to identify and outline conflicts of interest, duty to report, and possible sanctions.

DEFINITIONS:

POLICY STATEMENT: It is the policy of the EBCI PHHS Division that all employees, contractors, and other persons acting on behalf of the EBCI identify, report, and refrain from any transactions or functions that could result in a real or perceived conflict of interest.

PROCEDURE/ GUIDELINES:

1) Identify Conflicts of Interest
   a. All EBCI PHHS employees and PHHS representatives are required to attest that they have been informed verbally or in writing as to the conflicts of interest policy, have access to the policy, and will abide by its requirements to identify, report and refrain from functions or transactions that would or could result in a perceived conflict of interest.
   b. EBCI PHHS employees will comply with Tribal law as prescribed in the Code of Ordinances regarding the Code of Ethical Conduct Sec 96-2.
   c. The EBCI PHHS programs that are required to meet the Centers for Medicare & Medicaid Services (CMS) requirements will adhere to the Code of Federal Regulations 42 CFR 455.238 – Conflict of interest.
2) Duty to Report- When an employee is approached by others to use influence, or believes that personal relationships, interests, or business will bias the employee's influence or decisions on EBCI purchases, transactions, leasing arrangements, or other transactions, the employee is required to disclose (in writing) this information to the appropriate supervisor immediately.
3) Sanctions
   a. Violations of Tribal ethics ordinances and this conflict of interest policy may result in administrative and criminal penalties.

AUTHORITY:

ATTACHMENTS:

REFERENCES:

POLICY #: **DRC04 Ethical Issue Reporting and Review Process**

SUBJECT: Ethical Issue Reporting and Review Process

PURPOSE: The purpose of this policy is to outline the reporting and review process of ethical issues within PHHS.

DEFINITIONS:

POLICY STATEMENT: Ethical considerations and a deliberative process is necessary to improve transparency within the PHHS division. This policy will assist with identifying and outlining an ethics reporting process, review and investigation of ethical issues, and results reporting methods.

PROCEDURE/ GUIDELINES:

1) When ethical issues are identified and are reported to PHHS, they may arrive by a variety of methods (compliance hotline, email, in-person, telephone, etc). Once received, all issue will be reported to the Secretary of PHHS.
2) Once issues are received by the Secretary of PHHS, the Secretary will review the issue and will create an ad hoc committee to assist with documentation and policy review.
3) The Secretary of PHHS will also report all pertinent information regarding ethical issue to the Principle Chief.
4) A thorough review/investigation of all documentation, policies, and procedures will be conducted and a final decision will be made in response to the ethical issue presented.
5) Once the review is complete, any additional reporting requirements or follow-up to any regulatory or licensing body will be the responsibility of the program involved with the ethical issue.
6) The involved program will also be responsible for reporting to affected shareholders.

AUTHORITY:

ATTACHMENTS:

Ethics Policy 12152020 signed 022

Signed Secretary Memo

The Cherokee Code

The Public Health Code of Ethics

REFERENCES:

QUALITY IMPROVEMENT & PERFORMANCE MANAGEMENT

POLICY #: **DQI03 Quality Improvement**

SUBJECT: Quality Improvement

PURPOSE: To promote a culture of quality within the Eastern Band of Cherokee Indians (EBCI) – Public Health and Human Services Division (PHHS) that includes an organization-wide management and staff philosophy of continuous quality improvement (QI) in programs, service delivery and community health outcomes.

DEFINITIONS:

Plan Do Study Act (PDSA): An iterative, four-stage, problem solving model for improving a process or carrying out a change.

QI Plan: Management approach to quality and what is to be accomplished (goals) over a defined time frame.

Quality: In public health terms, quality is the degree to which policies, programs, services and research for the population increase desired health outcomes and conditions in which the population can be healthy *(Public Health Quality Forum, US Department of Health & Human Services).*

Quality Assurance (QA): Assurance of quality is the planned and systematic activities implemented in a quality system so that quality requirements for a product or service will be fulfilled *(American Society for Quality (ASQ)).* Quality Assurance may also be defined as a retrospective review of processes, programs, and services. It provides for the systematic monitoring and evaluation of the various aspects of a project or service to ensure that standards of quality are being met. QA is frequently used to guarantee quality.

Quality Improvement (QI): Use of a deliberate and defined improvement process, such as Plan-Do-Study-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community *(Accreditation Coalition 2009, Public Health Foundation, et.al.).* QI is frequently used to raise quality

POLICY STATEMENT: The Public Health and Human Services Division will objectively, systematically, and continuously assess, assure, monitor, evaluate, and improve the quality of processes, activities, programs, and services provided to the Eastern Band of Cherokee Indians (EBCI) community. This requires establishing agency-wide and/or specific program goals, objectives and measures (performance indicators) and includes training staff in QI methods and tools. To execute this policy, the PHHS will establish and implement an agency-wide bi-annual QI Plan.

PROCEDURE/GUIDELINES: Key components of the plan will include, but not be limited to:

- Describe key terms so that everyone has the same vocabulary when it comes to the terms used to describe quality and QI.

- Describe how the quality program will be managed and monitored by the organization.

- Describe the process for selecting QI projects and team leaders.

- Describe the types of training and support that will be available to the organization as a whole, facilitators, team leaders, and team members.

- Describe the quality process (i.e.: Plan-Do-Study-Act (PDSA)) and quality tools and techniques to be utilized throughout the organization.

- Describe how updates to planned QI activities and processes will be communicated to management and staff on a regular basis to keep them informed as to what progress is being achieved.
- Describe any quality roles and responsibilities that will exist in the organization (i.e., sponsor, team leader, team member, facilitator, etc.) during or after implementation.

- Describe how measurement and analysis will be utilized in the organization and how they will help define future QI activities.

- Describe any evaluation (Quality Assurance) activities that will be utilized to determine the effectiveness of the QI Plan's implementation.

The QI Plan will be presented to the PHHS Executive Committee for review and approval on a bi- annual basis. At the end of the calendar or fiscal year in which the plan is implemented, PHHS leadership/executive team will review the quality improvement activities conducted during the year, including the targeted process or program outcomes, the performance indicators (measures) utilized, the findings, data aggregation, assessment, and the QI initiatives taken in response to the findings. These documents will also be reviewed by the PHHS Secretary and/or her designees.

AUTHORITY: N/A

ATTACHMENTS: N/A

POLICY #: **DQI01 Performance Management (PM) System**

SUBJECT: Performance Management (PM) System

PURPOSE: The purpose of the Performance Management System is to monitor the quality of performance of Eastern Band of Cherokee Indians (EBCI) Public Health & Human Services (PHHS) processes, programs, interventions and other activities; improve public health practice and human services; and ultimately improve the health of the population.

Performance Management System- is a systematic process by which an organization involves its employees in improving the effectiveness of the organization, while also achieving the organization's mission and strategic goals.

Performance Standards- are standards or guidelines used to assess an organization's performance. Performance standards can be descriptive (e.g., A system for communicable disease control is maintained) or numerical (e.g., At least 80% of health department clients rate services as "good"). Performance standards answer the question, "Where should we be?"

Performance Measures- are quantitative measures of capacities, processes, or outcomes relevant to the assessment of a performance indicator (e.g., actual percentage of clients who rate health department services as "good"). Performance measures look at what happened compared to what was planned or intended.

Performance Indicator- A performance indicator or key performance indicator (KPI) is a type of performance measurement. KPIs evaluate the success of an organization or of a particular activity in which it engages.

Reporting of Progress- is how performance data is shared with stakeholders. This report may include comparisons to national standards or benchmarks.

Quality Improvement- in public health is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health

Results-Based Accountability™ ("RBA")- is a disciplined way of thinking and taking action used by communities to improve the lives of children, families and the community as a whole. RBA is also used by agencies to improve the performance of their programs.

PHHS Management Team- consists of the secretary, all directors, all managers and any personnel identified to attend the manager's meeting.

POLICY STATEMENT:

Use a performance management system to monitor the achievement of organizational objectives.

- Through a PM System, PHHS will evaluate actual results against planned or intended results.
- Through a PM System, PHHS will demonstrate accountability and good stewardship of resources.
- PHHS will measure progress toward program and population results through consistent application of PM.
- PHHS will use quality improvement tools and techniques to determine opportunities for programmatic and organizational improvement.
- PHHS will create reporting within departments and across the organization, to determine next steps and assure accountability.

Organizing Structure:

- The PHHS Management Team will do the following:
  - Include staff in developing performance management objectives and measures.
  - Monitor, track, and report progress on objectives and performance measures. Reports will be made at minimum on a quarterly basis.
  - Analyze and interpret results, identify opportunities for improvement, and determine and implement the best course of action. Additional data not included as performance measures may be used for the analysis.

- The Quality Improvement and Performance Management Committee:
  - Reviews and provides support on all aspects of the Performance Management System.
  - Following the completion of quarterly reports, analyzes division results.
  - Reviews and prioritizes quality improvement projects based on performance management results, strategic plan implementation, customer satisfaction, and process inefficiencies.
  - Evaluates the Performance Management System periodically and recommends changes necessary to keep it useful and relevant.

PROCEDURE/ GUIDELINES:

1. Performance Standards
   a. The Management Team identifies relevant standards, selects indicators, set goals and targets, and communicate expectations within all PHHS Programs.
2. Performance Measurement
   a. The Management Team refine indicators, define measures, develop data systems, and collect data within all PHHS Programs.
3. Reporting Progress
   a. The PHHS Management Team analyzes and interprets data, reports, results, and develops a regular reporting cycle within all PHHS Programs.

4. Quality Improvement

   a. The PHHS Management Team use data for decisions to improve policies, programs, and outcomes.
      i. Manage changes.
      ii. Create a learning organization
5. Reporting frequency will be contingent on the nature of the indicator and the needs of the division.
6. Training
   a. New hires will receive a Performance Management Overview.
   b. All staff will receive training on the individual program's PM procedures.
7. The Performance System will use the Public Health Foundation's Performance Management System Framework and will incorporate RBA.

AUTHORITY:

ATTACHMENTS:

REFERENCES:

Public Health Foundation: www.phf.org
Oneida Nation: www.oneida-nsn.gov
Minnesota Department of Health: www.health.state.mn.us
Clear Impact: www.clearimpact.com
Wikipedia: https://www.wikipedia.org

EPIDEMIOLOGY

POLICY #: **DEPI01 Public Health Surveillance**

SUBJECT: Public Health Surveillnce

PURPOSE: To ensure public health surveillance for reportable communicable diseases and conditions is done in accordance with local and state laws with the recommendations of the Centers for Disease Control and Prevention.

DEFINITIONS:

Active surveillance: the ongoing systematic collection and analysis of data about a specific disease or condition where the information is collected in real-time by a trained observer.

Passive surveillance: the ongoing systematic collection and analysis of data about an infectious disease as reported by health care providers in the routine practice of medical care.

Surveillance staff: Communicable disease program staff (data entry clerks, clinicians, epidemiologists, etc.).

NC-EDSS: North Carolina Electronic Disease Surveillance System.

POLICY STATEMENT:
The Eastern Band of Cherokee Indians Public Health and Human Services Division will conduct surveillance for reportable communicable diseases and conditions according to local and state laws and in accordance with the recommendations of the Centers for Disease Control and Prevention.

PROCEDURE/ GUIDELINES:

- The health director will assure that a trained surveillance staff is available to conduct active and passive surveillance for reportable diseases and conditions and other diseases affecting public health.
- Surveillance staff will be able to function in both paper-based and NC EDSS environment.
- Surveillance staff will notify and inform all health care providers in their county of the duty to report communicable diseases.

- Staff will educate health care providers in their county as to the method of reporting communicable diseases to the local health department and provide them with access to the necessary reporting forms.
- The health director will assure that the staff has a secure facility equipped with the electronic technology required for surveillance activities.
- The health director may request regional, state, and/or federal resources to assist in communicable disease surveillance and reporting, especially during outbreaks of communicable disease.
- Immediate investigation of reportable diseases and conditions will be followed by prompt reporting to the NC Division of Public Health. Some diseases are immediately reportable to the DPH by telephone, others within 24 hrs. of report to the LHD, and others within 7 days. Refer to NCAC 10A NCAC 41A .0101 and .0103.
- Staff will analyze surveillance data quarterly and incorporate analysis of data into bi-annual community assessment profile. Data will be used to monitor health status of the community and implement public health control measures as needed.

AUTHORITY: The authority for this policy is derived from The Cherokee Code ʃ130-300(Rules for the Administration of Public Health).

ATTACHMENTS: N/A

REFERENCES: N/A

ENVIRONMENTAL HEALTH

Policy #: DENV01 Environmental Health and Safety Complaint Investigation Process

Subject: Environmental Health Complaint Investigation, reporting and follow up process

Purpose: To ensure a thorough and timely investigation for environmental health related complaints.

Policy Statement: The Public Health and Human Services (PHHS) Division's Environmental Health program investigates complaints with regards to environmental health concerns. Examples can include water, waste disposal, food, animal or disease outbreaks. Upon receipt of a complaint relating to an environmental health concern, the PHHS Divisions Environmental Health Specialist (EHS) shall investigate and/or refer the concern to the appropriate authorities having jurisdiction.

Procedure/Guideline:

1. Upon receipt of a complaint via email or telephone for example, the EHS shall document the complaint using the appropriate investigation form.
2. The EHS shall investigate and/or refer the complaint to the appropriate authorities having jurisdiction. E.g., County Health Department or Tribal Division.
3. All complaints will be investigated in a timely manner. Usually within 24 to 48 hours and/or sooner depending upon the nature and severity of the complaint.
4. If the complaint is forwarded to another Division or County, the EHS shall follow up to ensure an investigation has been completed.
5. The EHS shall assist with any investigation upon request by a Tribal Division or County.
6. All documentation shall include a final resolution of the concern and shall be signed and dated.
7. Documentation shall be filed for future reference and a copy made available to the complainant upon request.

Authority: Public Health Director and/or Environmental Health Program Manager

Attachments: Complaint Investigation Form (See attached)

Update: 06/11/2021

References: File

COMPLAINT FORM.docx

EBCI PHHS DIVISION PLANS

Eastern Band of Cherokee Indians

Public Health & Human Services Division

Tactical Communications Plan

Appendix of the Public Health and Human Services Division All-Hazards Plan

Last Updated 6-16-21

TACTICAL COMMUNICATIONS PLAN

Record of Revisions and Approvals

This plan has been approved and adopted by:

06/16/2021

Vickie L. Bradley

Date

Secretary

Public Health & Human Services Division

Revisions

Date	Revision Number	Description of Change	Pages Affected	Reviewed or Changed by

For questions about this plan, contact:
Lyndsey Henderson, Preparedness Coordinator
lyndhend@nc-cherokee.com 828-359-1500

Plan Development and Maintenance

The primary responsibility for the development and maintenance of the Public Health Tactical Communications Plan belongs to the Preparedness Coordinator with the Public Health and Human Services Division (PHHS). The plan will be reviewed and updated annually with the acknowledgment that this is a living document under continual refinement and improvement. Reviews and updates may reflect changes in planning or guidance standards; plan activation or exercises that show areas of improvement; changes in the jurisdiction's demographics, hazards, or threat profile; the enactment of new of amended laws, ordinances, or policy changes.

All changes are subject to approval by the Public Health and Human Services Division Secretary and Public Health Director or designee.

Executive Summary

The ability to have a continuous flow of critical information within disciplines and jurisdictions is essential to establishing command and control, maintaining situational awareness, and to overall operations of emergency or disaster incidents. To strengthen emergency communications capabilities, this plan focuses on the technology, coordination, governance, usage, and training critical to directives and information about response status.

Purpose

Public Health and Human Services recognizes the need for interagency communication, interoperability, and cooperation. The Tactical Communications Plan describes the methods, procedures, and resources used by PHHS for efficient communication both internally and externally during an incident. Tribal Public Safety programs and Cherokee Indian Police Department have well-established interoperability capabilities in place, there is a need to facilitate information transfer between PHHS and other divisions or tribal entities that support operations, intelligence, logistics, and administration, all necessary to emergency exercises and events.

Scope

PHHS maintains a wide range of communication and information system resources to guide Tribal emergency communication between Public Health and Human Services, Emergency Management, and other disciplines. This includes provisions for redundant and interoperable systems for voice

communication, document/data transmission, and event/incident management purposes including situational awareness and reporting, messaging and mission coordination, mapping, and inventory/asset management. It will be used at the agency command level for routine communications, during critical incidents or by the discretion of the Secretary of PHHS. Media and social media communication procedures are covered in the PHHS Organizational Branding & Communications Plan.

Situation and Assumptions

While tactical communications entail a range of information it especially conveys managerial orders and decisions being disseminated by the Secretary of PHHS or Unified Commanders. Tactical communications must:

- Be operable (functionally useful) 24/7
- Be interoperable (able to work with other agencies)
- Meet their everyday internal and emergency communication requirements.
- Comply with NIMS by utilizing common talk

Other tactical communications planning and considerations includes:

- Tactical communications shall have an appropriate level/capability of redundancy/backup
- Tactical communications shall be established at the earliest possible time during the setup of the LRS and POD.
- Tactical communications shall be established between the LRS & POD, EOC, treatment sites & Cherokee Indian Hospital Authority, Public Health Coordination Center (PHCC), Tribal and county EM, State Public Health Coordination Center and NC Emergency Management, Cherokee Central Schools, Tribal Fire and EMS, Cherokee Indian Police

Establishing Communications

Because we need incident management and emergency responders to make timely decisions during an incident that involves multiple disciplines without technical or procedural communication impediments, different communication modalities have been identified between agencies.

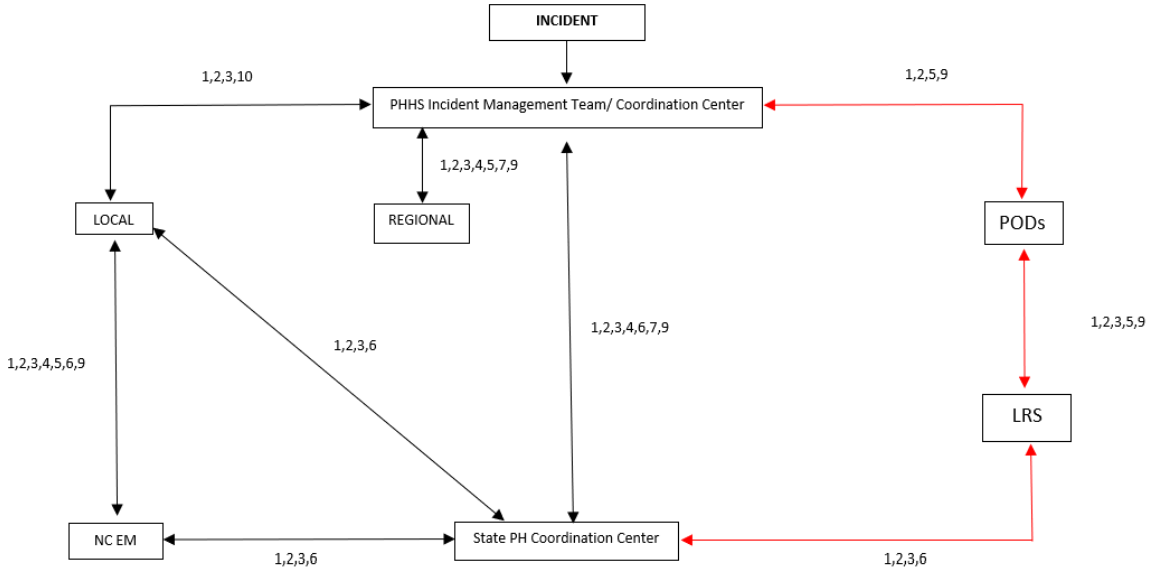
Communication support also enables: 24/7 operability; oversight of MCM inventory and supplies, timely status reports to the event command and control, driver reports of deliveries and en route problems; orders from points of dispensing (PODs) and treatment centers for assets; and coordination with law enforcement for protection and traffic/crowd control.

The Secretary of PHHS will authorize/ coordinate tactical message delivery with the following contacts:

- PHHS Public Information Officer
- PHHS Incident Management Team/Coordination Center

- Local contacts: CIHA, Tribal EM, Cherokee Central Schools and other educational/childcare settings, Executive Office, Cherokee Fire and Rescue, Cherokee Indian Police Department; MOA Counties if incident is multi-jurisdictional
- Regional and state response entities: PHP&R, MAHPC, NCEM, State Health Director, Epidemiologist
- National/ interstate contacts: CDC, United South and Eastern Tribes (USET)

The table below depicts the flow and modalities of communication between Tribal, regional, and state partners. Their contact information is listed in the section of this plan titled "Emergency Contact Information."



LEGEND			
1	Landline	7	NC HAN
2	Cellular Phone	8	Epi X
3	Email	9	GETS Card
4	Fax	10	Paper Messaging
5	800MHz Handheld Radio	11	Satellite Radio
6	WebEOC		

If all tactical communication systems fail, runners with handwritten messages will be used.

Activation

Activation of the plan will be incident-specific and as ordered by Incident Commander(s). Tactical communications will be dictated and coordinated through the EOC once the Tribal Incident Command System is stood up.

When an incident occurs, the PHHS Incident Management Team/Coordination Center will be stood up. Generally, the staff on this team are: the Secretary of Public Health, the Public Health Director, Operations Director, Public Relations Specialist, Nursing Supervisor, Preparedness Coordinator, Epidemiologist, and Environmental Health and Safety Manager. Other staff may be assigned based on incident or surge needs.

Tactical Communications Resources

TACTICAL COMMUNICATIONS SYSTEMS				
Purpose	**Priority**	**Resource**	**Information**	**Quantity**
Voice Communications	1	Landline Telephones	Desk phones that need connection to the internet to function. The primary mode for PHHS staff to communicate internally and with other partnering agencies. Requires electricity and internet.	All PHHS Staff
	2	Cellular Phones	Mobile phones also need connection to internet or cell tower to function. Must be text capable. Secondary mode for voice communication for PHHS staff but also a resource for e-mail and communication when phone services are disrupted through	(3) Work-issued

			text messaging services.	
	3	VIPER 800mHz radio	These radios (mobile and portable) operate as part of the VMN radio system. Provides Preparedness Coordinator with a redundant mode for voice communications with PHP&R and other agencies.	(1) Preparedness Coordinator
	4	GETS Card	GETS is a program operated by the National Communications Service (NCS) and is part of the Dept. of Homeland Security. The costs for GETS are paid for by NCS. A GETS card provides priority service for government officials through the PSTN or landline telephone system. You must be able to get a dial tone in order to make a GETS call. GETS does not provide priority service through the cellular telephone system. A GETS call can be sent to and received from a	(4) PHHS Secretary, Operations Director, Public Health Director, Preparedness Coordinator

			cellular number as long as there are cellular circuits available.	
	5	Satellite Telephones	MAPHC maintains a satellite telephone. This is a "Last Call" telephone/radio system provides voice communication capability when power is out or other communications systems fail. Requires satellite availability and must be "activated" prior to use.	(0)
Document/ Data Transmission	1	Email	Provided through smartphone or computer but requires internet connection to function. Primary mode for staff to transmit documents and data with each other and with other partnering agencies.	All PHHS Staff
	2	WebEOC	Web interface with State EOC and emergency management operations statewide, hospitals/hospital emergency management staff, regional HPCs, and HPP/NCOEMS	NA

			organizations/staff with statewide/regional status boards and messaging. Used to maintain situational awareness, for internal posting and coordination of ESF-8 situational awareness, resource/mission requests, and reporting (IAP, situation reports, ICS forms), file library, secure messaging.	
	4	Fax	No computer of internet required. Provides redundant data transmission capability when internet/power is out.	(1)

Other PHHS tactical communication equipment includes:

- (12) Motorola Walkie-talkies
- (8) Kenwood Two-way Radios

Should tactical communications overlap with public communications the following methods of information dissemination will be utilized:

- County and Cherokee Central Schools ConnectED messaging system
- Radio
- Television
- Newspapers
- CodeRed

Training and Testing of Systems

The Preparedness Coordinator is responsible for training and testing of tactical communication equipment and methods.

The Preparedness Coordinator or designee will conduct quarterly training and testing of systems will be conducted. Alternate schedules of training and testing will be a result of updates in policies and procedures, a change of staff or phone numbers, or by assignment of the Secretary of Public Health & Human Services or Public Health Director.

The Preparedness Coordinator will determine participants, conduct and record the drills, and complete After-Action Reports and Improvement Plans as assigned. The Preparedness Coordinator will ensure a timely follow-up of improvement steps and will record their completion on the AAR within 120 days of the initial drill.

During an incident, the incident Communications Unit will be responsible for programming equipment as needed, JITT and equipping response personnel. All communications equipment will be demobilized through the incident Communications Unit or Comm Unit personnel deployed to the SNS POD.

System	Utilized/Tested	Who Utilize/Test	Training
Landline **Telephone**	Normally in use daily	All PHHS Staff Tribal EM CIHA Law Enforcement Cherokee Fire & Rescue	In-house, if needed
Cell Phones	Normally in use daily	All PHHS Staff Tribal EM CIHA	NA

		Law Enforcement Cherokee Fire	
E-Mail/Email List Serves	Normally in use daily	All PHHS Staff Tribal EM CIHA Law Enforcement Cherokee Fire	In house, if needed
800 MHz Radios	Normally in use weekly	PHHS Preparedness Coordinator Tribal EM CIHA Law Enforcement Cherokee Fire	PHP&R/PHRST 6
Web EOC	As incident occurs	PHHS Preparedness Coordinator Tribal EM	PHP&R, PHRST 6
NC HAN Alert	Quarterly	PHHS Preparedness Coordinator, Public Health Director, Epidemiologist	PHP&R, NC HAN Administration
Epi-X	Daily information	PHHS Epidemiologist	NA

Written Paper Messages	Normally in use daily	All PHHS Staff	NA
GETS Card	Monthly	PHHS Staff- Secretary, Operations Director, Public Health Director, Preparedness Coordinator	

Emergency Contact Information

Training and testing of tactical communications systems will be done with core partners of EBCI. Core partners (identified in the table below) are agencies or programs who are essential to local emergency response and tactical communications. Other resources are listed for reference but are not required to be tested on a quarterly basis.

EBCI Core Partners			
Agency	**Contact Person**	**Phone Number**	**Email**
Cherokee Indian Hospital Authority	Dr. Richard Bunio, Executive Clinical Director	Office: (828) 497-9163 ext. 6390 Work Cell: (828)788-4633 Fax: (828) 497-2185	richard.bunio@cherokeehospital.org
	Jason White, Pharmacy Director	Office: 828-497-9163, ext. 6366	jason.white@cherokeehospital.org
	Sally Penick, Infection Control	Office: (828) 497-9163	sally.penick@cherokeehospital.org
Tribal Emergency Management	Mollie Grant, Program Manager	Office: (828) 359-6430	mollgran@nc-cherokee.com
Executive Office	Ashleigh Stephens, Chief of Staff	Office: (828) 359-7029	ashlstep@nc-cherokee.com
Cherokee Indian Police Department	Gene Owl, Chief of Police Erik Oswalt	Office: (828) 736-9369 (828) 735-2899	geneowl@nc-cherokee.com erikoswalt@nc-cherokee.com
Cherokee Fire & Rescue	Curtis Arneach, Fire Chief	Office: (828) 359-6150	

Cherokee Central Schools	Yona Wade, Director of Community Affairs	Office: (828) 554-5032	yona.wade@ccs-nc.org

Resources and Partners			
Agency	**Contact Person**	**Phone Number**	**Email**
NC Office of Public Health Preparedness & Response Main No. 919-546-1820 or 919-715-0919 **PHP&R 24/7 On-call 888-820-0520**	Brian Combs, Branch Head and Public Health Emergency Preparedness (PHEP) Director	Office: (919) 546-1821	brian.combs@dhhs.nc.gov
PHP&R WRO	Ben Barham, Planning Consultant	Work Cell: (919) 604-5375	benjamin.barham@dhhs.nc.gov
	Keith Rowland, Industrial Hygienist	Work Cell: (828) 450-5842	keith.rowland@dhhs.nc.gov
	Billy Krepps,	Work Cell: (828) 200-4003	william.krepps@dhhs.nc.gov
Jackson County Department of Public Health	VACANT		
Swain County Health Department	Stacy Parris, Preparedness Coordinator	Office: (828) 736-0343	stacyp@swaincountync.gov
Graham County Health Department	Emily Collins, Preparedness Coordinator	Office 828-479-7900	emily.collins@grahamcounty.org
Cherokee County Health Department	Phillip Anderson, Preparedness Coordinator	Office: (828) 835-3853	philip.anderson@cherokeecounty-nc.gov
Haywood County Health Department	Jeanine Harris, Preparedness Coordinator	Office: (828)-356-2250	jeanine.harris@hayoodcountync.gov
Mountain Area Healthcare Preparedness Coalition (MAHPC)	Mark Stepp, Healthcare Preparedness Coordinator	Office: (828) 693-6212 Cell: (828) 775-0775	mark.stepp@hcahealthcare.com

Eastern Band of Cherokee Indians

Public Health & Human Services Division

QUALITY IMPROVEMENT/

PERFORMANCE MANAGEMENT PLAN

Last Updated 5-6-21

QUALITY IMPROVEMENT/PERFORMANCE MANAGEMENT PLAN

RECORD OF APPROVAL AND REVISION

This plan has been approved and adopted by:

Vickie L. Bradley — 5/10/21

Vickie L. Bradley — Date

Secretary

Public Health & Human Services Division

Revisions

Date	Revision Number	Description of Change	Pages Affected	Reviewed or Changed by
10-1-20	1	Applied revisions from Public Health Director & Secretary	2	Timothy Triplett, Quality Improvement Coordinator
11-18-20	2	Applied revisions from Public Health Director & Secretary	2	Timothy Triplett, Quality Improvement Coordinator
5-6-21	3	Formatted Plan & Reviewed	All	Sheena Kanott Lambert, Public Health Director

For questions about this plan, contact:
Tim Triplett, Quality Improvement Coordinator
timotrip@nc-cherokee.com 828-200-4536

Table of Contents

Eastern Band of Cherokee Indians

Public Health & Human Services Division Mission, Vision and Values

The QIPM plan addresses culture and process improvement efforts required to

support the following Mission, Vision, and Values of EBCI Public Health and Human Services.

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OUR MISSION

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HONORING our Cherokee Community by PROVIDING excellent care, PROMOTING health, and

SERVING families in a culturally respectful way

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OUR VISION

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Seven Generations of wellness with families strong in mind, body and spirit

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COMMUNITY VALUES

ᎤᏣᏙᏐᏴᏓ ᎢᎦᏓᏍᎾᎢ	*Group Harmony*
ᎦᎦᏚᏁᎢ	*Interconnectedness*
ᎤᏣᏂᎩᏓ ᎠᏓᏛᏁᏗ - ᏚᏣᎪᏛᎢ	*Strong Individual Character*
ᎠᏙᎡᏐᏍᏩᏗ ᎠᏯᏛᏗ	*Compassionate Service*
ᎠᎦ4ᏙᏗ	*Commitment to Stewardship*
ᎠᎡᏋᎡᏍᏙᏗ ᎠᏂᏣᎳᎩ ᎠᏁᏓᎢ	*Respect for Cherokee Heritage*
ᏧᎬᏩᎶᏗ ᎠᏂᏏᏓᏁᎡ	*Value Families*

ᏅᏯᏍᏗ ᎠᏓᏅᏖᏗ *Sense of Humor*
ᏛᎰᏩᏏᎾᎥᎾ *Generosity*
ᎠᏕᎱᏂᎢᏍᏗ *Enthusiasm*

OVERVIEW AND PURPOSE

The Eastern Band of Cherokee Indians (EBCI) is North Carolina's only federally recognized Tribe and the First American Indian/Alaska Native (AI/AN) Tribe with a written language, created by Sequoyah in 1821. The jurisdictional boundaries of EBCI include more than 56,000 acres of largely rural, mountainous land in the five westernmost NC counties (Cherokee, Graham, Haywood, Jackson and Swain). The largest contiguous parcel of EBCI trust land is the Qualla Boundary, which spans the Jackson and Swain County border and includes the town of Cherokee. The Qualla Boundary contains approximately 45,550 acres.

EBCI has over 16,000 enrolled members and a sovereign Tribal government with an elected Principal Chief, Vice Chief, twelve Tribal Council representatives, and a Tribal Court. Cherokee Indian Hospital Authority (CIHA), located in Cherokee, is an 18-bed compacted Tribal hospital with a primary care clinic with over 11,000 users.

In 2013, it was the intent of Tribal Leadership to develop a fully integrated public health and social services Division, and in 2015 PHHS established the Human Services Department. After going live with Human Services, PHHS leadership began a reorganization plan for the PH section of the Division. This reorganization included completion of an assessment of all PH related services, gap analysis, and a strategy to merge similar services (e.g., diabetes prevention, health education, women's wellness, and Women, Infants and Children (WIC) to mirror traditional local/county PH departments – to move past the historical Health Indian Services (HIS) model.

PHHS embraces the sociological model for the Tribal Community and is committed to redesigning from the inside out to increase capacity by coordinating, improving and innovating services in the Cherokee Cultural context an embracing the current wide spectrum of partnerships to decrease duplication and gaps. To this end, PHHS has participated actively in the National Indian Health Board's

Tribal PH Accreditation Advisory Board, United South and Eastern Tribes (USET), PH Improvement Training, PH Performance Improvement Network (PHPIN), and other PH initiatives in Indian Country.

PHHS is the largest EBCI Division with approximately 236 employees and is designated as Public Health authority, though the state of North Carolina does not recognize PHHS as an independent health department. PHHS compromises over 19 programs across the spectrum of PH. The organizational vision is seven generations of wellness with families strong in mind, body, and spirit.

The purpose of the QIPM Plan is improving the efficiency, effectiveness, and reliability of public health processes. It is a guidance document that informs everyone in the organization as to the direction, timeline and activities related to quality improvement. These principles will be incorporated throughout all programs and promote ongoing efforts to increase communication and improve work functions. The QI plan will provide the framework by which the development, monitoring, and evaluation component will be facilitated. This plan is linked in a coordinated fashion with the Workforce Development Plan and PHHS Strategic Plan.

PERFORMANCE MANAGEMENT

BACKGROUND:

Public Health Performance Management System

Performance Management is a systematic process by which an organization involves its employees in improving the effectiveness of the organization, while also achieving the organizations mission and strategic goals.

By improving performance and quality, public health systems can save lives, cut costs and get better results. Performance management enables health departments to be more efficient, effective, transparent, and accountable.

The performance management model used by PHHS was developed by the Turning Point National Excellence Collaborative on Performance Management.

According to the Public Health Foundation, performance management is the “practice of actively using performance data to improve the public’s health.”

PUBLIC HEALTH PERFORMANCE MANAGEMENT SYSTEM

Developed in 2013, adapted from the 2003 Turning Point Performance Management System Framework

The model includes the following components:

Performance Standards are standards or guidelines used to assess an organization's performance. Standards are based on national, state, and scientific guidelines; and other methods, including benchmarking against similar agencies and setting benchmarks based on agency expectations. Performance standards can be descriptive (e.g., A system for communicable disease control is maintained) or numerical (e.g., At least 80% of health department clients rate services as "good"). Performance standards answer the question, "Where should we be?"

Performance Measures are quantitative measures of capacities, processes, or outcomes relevant to the assessment of a performance indicator (e.g., actual percentage of clients who rate health department services as "good"). To determine performance measures, PHHS utilizes national tools containing pre-existing measures in addition to creating new performance measures based on agency need. Performance measures look at what actually happened compared to what was planned or intended.

Reporting of Progress is how performance data is shared with stakeholders. This report may include comparisons to national standards or benchmarks.

Quality Improvement (QI) is the process by which processes, policies, programs, and infrastructure are enhanced and improved upon by using program evaluation models such as Plan-Do-Check-Act and Rapid Cycle Improvement. Program evaluation is a key component of quality improvement since the success of programs must be measured in order to determine whether quality improvement action is warranted.

Results Based Accountability is a framework for moving from talk to action in a disciplined manner. It is evidence based, action oriented, and data informed. RBA is used to plan, evaluate and improve projects, programs, and community-wide efforts. The framework helps people describe the contribution their work makes to the health and well-being of their community overall. Three core principles of RBA include "Common Ground" (allowing focus on the desired results in mind), "Common Language" (building trust for all involved by using clear and simple words), and using "Common Sense" (keeping things easy to follow by using a straight-forward, step by step approach). RBA starts with the "ends" first. The desired outcome is the starting point in this framework, not the actual finish line.

Performance Management System functionality throughout PHHS:

The 2020 QIPM plan aligns strategic operations in the Workforce Development Plan and Strategic Plan. This will be accomplished by encouraging frequent QI activities supported to improve performance at all levels Division wide. Additional collaborative measures include policy development, monitoring, and the development of a workforce ready population focused on training and organizational culture.

PERFORMANCE MANAGEMENT OVERVIEW:

Purpose: Culture of Quality

This section provides a brief description of the culture of quality and the desired future state of quality in the organization. These efforts include work roles and responsibilities, processes, and staff engagement. As of 2021, PHHS is a Division of 236 employees in 19 distinct service programs with a wide variety of sizes, scopes, and service offerings. PHHS programs include the following: emergency response, regulatory, surveillance, educational, specialized clinical, residential, home-based, and/or preventive services. Some PHHS programs are regulated, accredited, and/or certified by Tribal entities. Individual programs differ on the quality measures that they must report to regulating agencies and grantors.

However, until recently, QI and PM initiatives have resided in individual programs and there has been no overarching, ongoing QI and PM system Division-wide. The wide variety in size and type of program, as well as the Principal Chief's mandate in 2015 to take on all human services for Tribal members, have made QI and PM a challenge for PHHS. In addition, there is very little available evidence base for QI and PM in Tribal public health entities. Tribal sovereignty and the unique characteristics of Tribal communities make this a journey with few landmarks specific to Indian Country.

Program-specific, decentralized QI measures are in place in most programs, but consistency and direction across the Division have been challenging. PHHS is beginning to determine the QI needs across the Division and to plan and implement a unified QI program that will demonstrate performance accountability to Tribal officials and the EBCI community in a rigorous, clear, and responsive fashion. PHHS aspires to establish a culture of QI across the Division that will respect programmatic differences but will decrease silos of information and performance. The future state of quality will place emphasis on clear and consistent communication of QI projects. This information will be shared through new staff orientation, cultural orientation, story boards, staff meeting updates and QIMDT meeting minutes.

The goal of PHHS is to develop and maintain a robust performance management system that involves the ongoing use of performance standards, performance measures, progress reporting and QI principles. This will be accomplished by:

- Providing effective, timely communication, education and follow up
- Engaging in an environment of continuous learning and improvement

- Setting specific performance standards that includes benchmarking (where possible) against similar agency, national, state, and scientific guidelines.
- Measuring capacity, process, or outcomes of performance standards.
- Reporting progress to stakeholders regularly.
- Integrating QI into agency operations through ongoing use of Plan-Do-Check-Act.

Performance management practices have been shown to measurably improve public health outcomes, create efficiencies working with partners, and help public health workers solve complex problems. Performance management practices can also be used to allocate resources, prioritize programs, change policies to meet goals, and improve the overall quality of public health practice.

PERFORMANCE MANAGEMENT PLAN ORGANIZATIONAL STRUCTURE:

The Quality Improvement Multidisciplinary Team (QIMDT)

The purpose of the QIMDT is to serve in a leadership role within the Division to develop and sustain a culture of quality. This panel is responsible for oversight of performance management efforts and for promoting, training, challenging, and empowering PHHS staff to participate in the on-going process of QI. The QIMDT will:

- Review and update the QIPM plan annually.
- Report QI and Performance Management Indicators to the executive team
- Define standards and measures that will be monitored during plan year.
- Link QI projects to performance management standards.
- Review QI projects submitted to the QIMDT Committee.
- Identify, monitor, and review results from QI projects by using PDCA model.
- Review program/service evaluations and identify processes that need improvement.
- Participate in designated QI training via webinars, conferences, or trainings.
- Collaborate with leadership to provide oversight of implementation, evaluation, progress and communication of report on QI projects.
- Involve staff through encouragement, training, and celebration of accomplishments.
- Encourage and foster a supportive QI environment.
- Apply QI principles and tools to daily work.

The Quality Improvement Coordinator will:

- Work with executive leadership to provide vision & direction for QI.
- Determine appropriate media outlets and messages to communicate selected performance results to the public.
- Delegate responsibilities to committee members
- Coordinate performance management and QI training

The QIMDT will conduct process and outcome evaluations to identify what is working well and identify opportunities for improvement. These findings will drive the Performance Management System. Evidence based tools (i.e. NACCHO's Self-Assessment Tool) will be used for evaluation purposes regarding data outcomes from staff surveys, questionnaires, document reviews and to develop training protocols. Adjustments to these processes will result in continuous performance improvement and measures of effectiveness throughout the timeline of the plan. Evaluation findings, data analysis, key program activities, strengths, and challenges will serve to guide planning to improve program effectiveness.

Staffing, Membership and Rotation

The Quality Improvement Coordinator (QIC) will select team members each plan year. Designated team members may participate on the team more than one year. A list of the PHHS organizational structure is listed in Appendix F.

Roles and Responsibilities of QIMDT members:

Committee Member	Responsibility
QI Coordinator (Committee Chair)	-Serve as chair and convene the QIMDT -Revise and update the QIPM plan annually -Work jointly with leadership to provide vision & direction -Facilitate QI team meetings (makes meeting arrangements including time/location/dates) -Request resources for activities -Delegates responsibilities to committee members -Documents all QI related activities (maintains QIMDT share file and other documentation) -Serves a 2-year term (consecutive terms are allowable if approved by Division Secretary)
Administrative	-Identify continuing education resources -Implement appropriate strategies to develop and sustain a culture of QI -Prepares agenda and calls meetings to order -Maintaining minutes

	-Assisting staff to track performance data
Divisional Secretary	-Provide leadership for Department mission & strategic plan related to QI -Oversee development of annual QIPM Plan and allocate resources -Serve as a member of the QIMDT -Report to Executive Leadership twice a year
Division Managers **Environmental Health & Safety Manager** **Public Health Director** **Lead Compliance Officer** **Preparedness Coordinator**	-Identify appropriate staff for QI teams (annually) -Oversee QI efforts within division -Facilitate QI teams as needed -Provide/Allocate administrative support to the QIMDT -Assure QI-related performance and/or professional development goal for all division staff -Encourage staff to incorporate QI efforts into daily work -Prioritize and select projects -Advise QI efforts within PHHS and assist with QI Project Teams as needed -Assist in providing access to QI tools and encourage completion of QI related performance management goals for all PHHS staff members -Encourage staff members to incorporate QI efforts into daily work (Review QI Plan, Workbook, Guidebook and Forms annually to ensure QI initiatives are supporting a Culture of Quality)

Financial Commitment and Resource Allocation

The primary budget allocation for QI projects and activities fall under administrative costs through the Division. As resources allow, budget line items may be dedicated to QI efforts, including the purchase of training materials, attendance at conferences, as well as technical assistance and consultation. PHHS QI initiative expenses are also covered by dept. budget as part of the total operational expenses, which includes one FT position (QI Coordinator).

Sustainability

Sustainability involves creating and building momentum to integrate QI processes into organizational routines utilized by PHHS employees. To achieve long term growth in QI, the following approach will be undertaken to create an environment to sustain the QIPM Plan:

* Maintain the QIMDT (and responsibility for the QI Plan and attainment of goals/objectives)

* Provide regular communication to leadership & employees regarding the QI Plan
* Integrate QI in training protocols for new employees and current employees.
*Review and update the QI Plan on a regular basis to support PHAB requirements and build QI performance within the agency.
*Contribute needed resources to ensure continuous growth in culture of QI.

Employee Training

PHHS employees will review the Strategic Plan and QIPM Plan within 6 months of hire. Additional training includes the QI power point presentation, and the Plan-Do-Check-Act Quality Improvement model. This training requirement aligns with the PHHS Workforce Development Plan. Employees may be required to participate in additional trainings in performance management and QI as assigned. QI activities will be included as a required activity for all staff. Employee involvement in QI activities will be assessed during the employee annual performance appraisal process.

PHHS has identified training needs based on competencies that are relatable to every field in the Workforce Development Plan. As Public Health employees, new and existing staff will need these trainings in order to conduct their day-to-day operations. The trainings consist of CPR/First Aid, Fire Safety, HIPAA, Respiratory Protection,

Compliance, Bloodborne Pathogens, FEMA Emergency Management, Performance Management, Quality Improvement and Historical Grief & Trauma. PHHS will require that each employee complete these trainings within their probationary period. New hire orientation will be ushered through PHHS Onboarding. If the determination is made that in person training is not in the best interest of PHHS staff, the Quality Improvement Coordinator will request approval for virtual training from the Public Health Director and/or Divisional Secretary.

The following PHHS training partnerships may be utilized in lieu of in person training:

- Western North Carolina Health Network (WNCHN): Results-Based Accountability (RBA) training and support; data analysis, Tribal Health Assessment and Improvement Process (THA/THIP) support, social determinants of health training and support.

- Western Carolina University Culturally Based Native Health Programs (WCU CNBHP): Culturally relevant staff orientation materials and cultural competencies, ACES, CEU's for PHHS staff, traditional foods and medicinal plants, community programming around public health, student rotations and internships and pre-professional programs for aspiring PH professionals

- National Indian Health Board (NIHB): technical assistance on PH accreditation, laws/policies in Indian Country, Tribal PH Accreditation Advisory Board (TPHAAB)

- Mountain Area Health Education Center (MAHEC): training and support, ACES, RBA, CEU's for health Professionals, student rotations.

Once staff have completed 1 year of service, 3 contact hours of continuing education will be required. These courses are as follows:

1. Quality Improvement Series: Differentiate between various tools for identifying problems, organizing ideas and presenting data. Also describe ways to prevent fatigue in the workplace. https://www.train.org/main/course/1074896/

2. Quality Improvement Team Development: Describe the importance of QI Teams including how to choose effective members for a QI team and define roles and stages of group development. https://www.train.org/main/course/1046422/

Advanced QI training for QIMDT members involves the completion of two on-line courses:

1. Ohio State University's Center for Public Health Practice: This training is designed specifically for state, local and tribal public health professionals. https://pmqitraining.miophi.org/

2. TRAIN Network - Data driven Quality Improvement Module 3: This training will focus on a variety of methods to collect, analyze and interpret data to inform quality improvement efforts. https://www.train.org/main/course/1077672/

QIMDT members will complete the following training after 12 months of membership:

1. Performance Improvement and Workforce Development Resources for Public Health Practice: Describe how quality improvement in public health is leading to improvements in health Outcomes. Additionally this course discusses the expanding array of tools and resources to improve health department quality and performance (3 hours) https://www.train.org/main/course/1032549/

The QIMDT and management team will decide on the most appropriate method in which the training will be facilitated. The minimum training requirement is 3 hours. Internally these trainings will be offered individually (at each program site), via web or at one specified location. Ensuring the information is shared in a manner that truly connects with PHHS employees and customers is very important. The QIMDT will provide a detailed annual training report at the end of each fiscal year.

Reporting Progress and Communication

PHHS is one of 19 programs within the Division. Programs report performance progress and QI projects through the QIMDT, facilitated by Quality Improvement Coordinator. Participation in this committee aligns common goals of QI and keeps PHHS informed on other QI activities throughout the division. QI activities will be included in annual reports submitted to the QIC. Upon initiation of QI projects, workgroup project leaders will enter the project into the divisional database. QI project progress will be documented and reported through this database. This annual report and filing system will serve as record of all formal QI projects completed by PHHS. Other ways of communication are leadership meetings, staff training, and the monthly column of "QI corner" in the PHHS newsletter (provided by the Quality Improvement Coordinator). This resource will provide staff insight on commonly used QI techniques, activities, and ways to improve efficiency in the workplace. Additional QI tools/concepts will be emailed to staff to raise awareness of upcoming trainings, surveys &

events. Progress will be reported annually to staff, executive leadership, and other interested stakeholders. Other audiences may include:

☐ Other local health departments ☐ Grant funders ☐ Community members ☐ Media

The following should be considered when developing a report:

☐ Is correct information presented?

☐ Is information presented accurately?

☐ What is the purpose of the report?

☐ Who is the critical audience?

Since performance reports can be misinterpreted, it is important to provide some context so those reading the report can understand and appreciate what is being reported. Following are some useful strategies to help assure performance reports are accurate, understandable, and send the correct message:

- PHHS management and QIMDT members will review performance data before it's reported out. This gives everyone an opportunity to consider what explanations are needed, including causes, rationales, recommendations, and/or corrective steps.
  - Tie information and data to goals and objectives. Goals and objectives provide a clear context, and identify what work is being measured against.
  - For results that may be worse than expected, include in the report an outline of a QI plan. When goals are not achieved, it helps to demonstrate that critical thinking has taken place, and that QI steps should increase future performance.
- The format of the report should be customized for the audience. Charts, tables, and maps are generally user-friendly and easy to understand.

Plan Evaluation

Based on the recommendations of the QIMDT, and divisional secretary, the plan will be revised annually to reflect program enhancements. Activities planned for the next year will be based on recommendations from the annual evaluation, and supported by the results of the annual staff QI Survey. This will be completed to allow PHHS staff to share their experience(s) with QI goals/projects, including department strengths and weaknesses, QI barriers, training needs, confidence in leading QI projects, comfort in using QI tools/forms, and understanding of the PHHS Performance Management Plan

and concepts. The survey will also gather suggestions for future QI projects (appendix E).

QUALITY IMPROVEMENT GUIDANCE

Quality Improvement (QI) background

While performance measures and standards are part of a performance management system that can be captured within a tracking system itself, QI requires a broader explanation and plan in order to reach a thorough and consistent understanding among staff, the oversight committee, and PHHS partners.

Basic principles for QI work include the following:

- Develop a strong customer (client) focus
- Continually improve all processes
- Involve employees
- Mobilize both data and team knowledge to improve decision-making

During the 2020-2021 plan years, PHHS will utilize a Plan-Do-Check Act (PDCA) approach within a Results Based Accountability framework. The QIPM plan incorporates data collected from the 2019 PHHS staff satisfaction survey to establish baseline measures.

PHHS will focus on 3 fundamental concepts in applying the PDCA cycle:

1. Developing a strong workforce with QI core competencies in place
2. Recognizing change as improvement by evaluation and data driven accountability.
3. Implementation of changes resulting in increased staff satisfaction, efficiency measures and measurable performance.

Plan-Do-Check Act Cycle

The American Society for Quality suggests using Plan-Do-Check-Act (PDCA) in the following ways:

- As a model for continuous QI.
- To develop a new or improved process, product, or service.
- To collect and analyze data to verify and prioritize problems or root cause.
- To implement change.

In applying the PDCA cycle, ask these fundamental questions:

1. What is PHHS trying to accomplish?
2. How will PHHS know that a change is an improvement?
3. What changes can PHHS make that will result in improvement?

PLAN

There are five steps in the planning stage:

- Identify the problem: Identify opportunities/ priorities that are meaningful and are identified by staff as an issue; should be supported by data.
- Assign workgroup: Identify who is going to work on the QI.
- Gather background/ research on the problem: Describe the current process using a flow chart, process map, and/or other useful tools. Identify root causes and potential solutions.
- Brainstorm solutions: Identify some possible solutions.
- Develop an improvement theory and aim statement: Pick one of the solutions identified. If we do X then Y will happen. Develop an aim statement to specify what success will look like; What? How much? By when? For whom?

DO

Take small steps to implement the solution on a limited scale, collecting data along the way. Test the plan for a limited time, on a limited basis, and in a limited area. Follow the plan carefully to ensure minimal deviation. The goal is to show whether the changes are effective and to avoid widespread failure if they are not. Data should be collated prior to moving on to the next step.

CHECK

Take time to determine if measurements used to determine success are adequate. If not, define required measurements and how/ where data can be found or developed. Analyze the data, and assess for success or unexpected outcomes.

ACT

There are two steps in the Act stage:

- Standardize or test a new theory: If the change resulted in the desired outcome, it can be fully adopted by standardizing and/ or expanding it to other areas of the agency. If the change did not result in improvement, abandon it and begin the PDCA cycle again.

- Establish Future plans: If some improvement resulted, adapt the change to achieve desired outcome and begin the PDCA cycle over again.

Goal 1 of the QIPM plan (page 22) focuses on developing a culture of quality in the workplace.

This table incorporates the PDCA cycle to determine a baseline of QI staff competency:

Indicator	Criteria	Status	Goal	Timeline	Total	Actual	Action	Follow up
Number of employees with successful completion of QI training modules	Observe/ Verify certificates obtained	Collecting Baseline	100%	12/15/20 - 03/1/21	100	Projected 90 (90%)	Resulting actions	Future plans
Plan				**Do**		**Check**	**Act**	

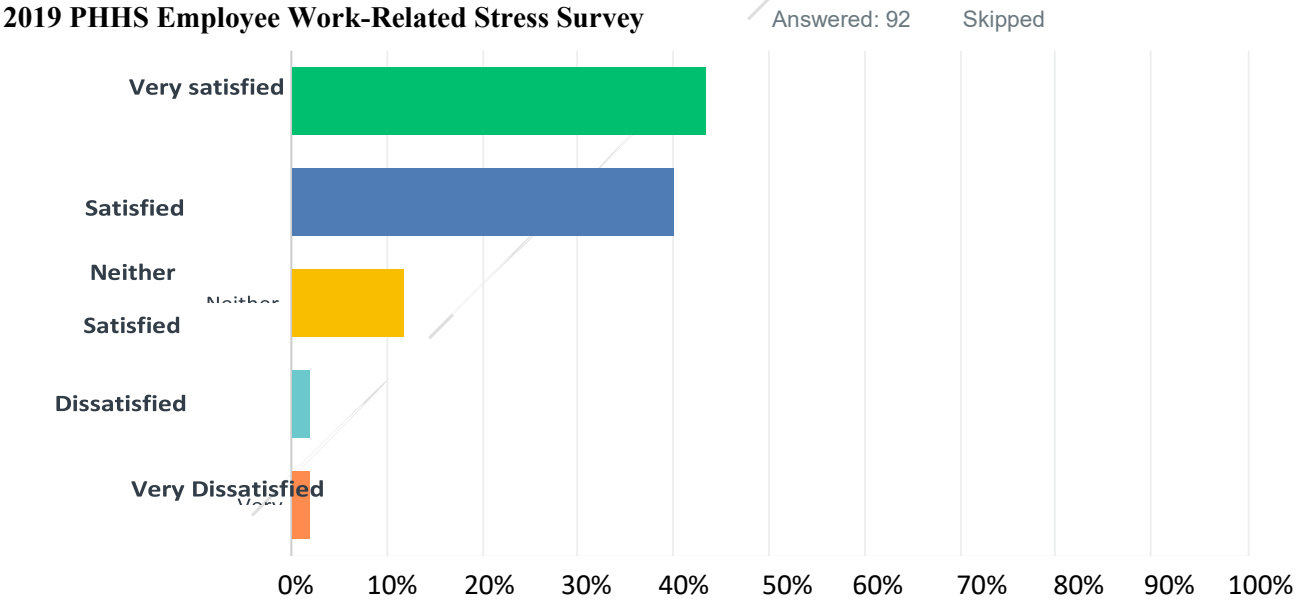
PHHS will use the RBA framework to focus on 3 key performance measures within survey data:

How much did we do?	How well did we do it?	Is anyone better off?
# of PHHS work force served **# of Activities** Pre/Post Staff Satisfaction and QI baseline surveys QI training activities QI Corner monthly article (PHHS newsletter) or QI webpage at PHHS site	**% Common measures** PHHS survey results indicating satisfaction levels, staff turnover rate, # of staff trained in QI via onboarding **% Activity-specific measures** Percent of staff completing QI activities, on-boarding requirements, actions meeting standards	**Skills/Knowledge** compare QI pre/post test scores **Attitude/Opinion** - data outcomes from pre/post surveys **Behavior** – turnover rates and staff performance **Circumstances** – what factors contributed to level of staff participation (i.e. unable to participate in an event due to lack of staffing, time of day, etc).

Plan Evaluation

Based on the recommendations of the QIMDT, and divisional secretary, the plan will be revised annually to reflect program enhancements. Activities planned for the next year will be based on recommendations supported by the results of the annual staff QI Survey, and evaluation results of the plan. This will be completed to allow PHHS staff to share their experience(s) with QI goals/projects, including department strengths and weaknesses, QI barriers, training needs, confidence in leading QI projects, comfort in using QI tools/forms, and understanding of the plan. The survey will also gather suggestions for future QI projects (appendix E). The 2020 QIPM plan will utilize a Results Based Accountability approach to assess satisfaction levels within the PHHS workforce. Goal # 4 will focus on 2 areas of the survey. This data included

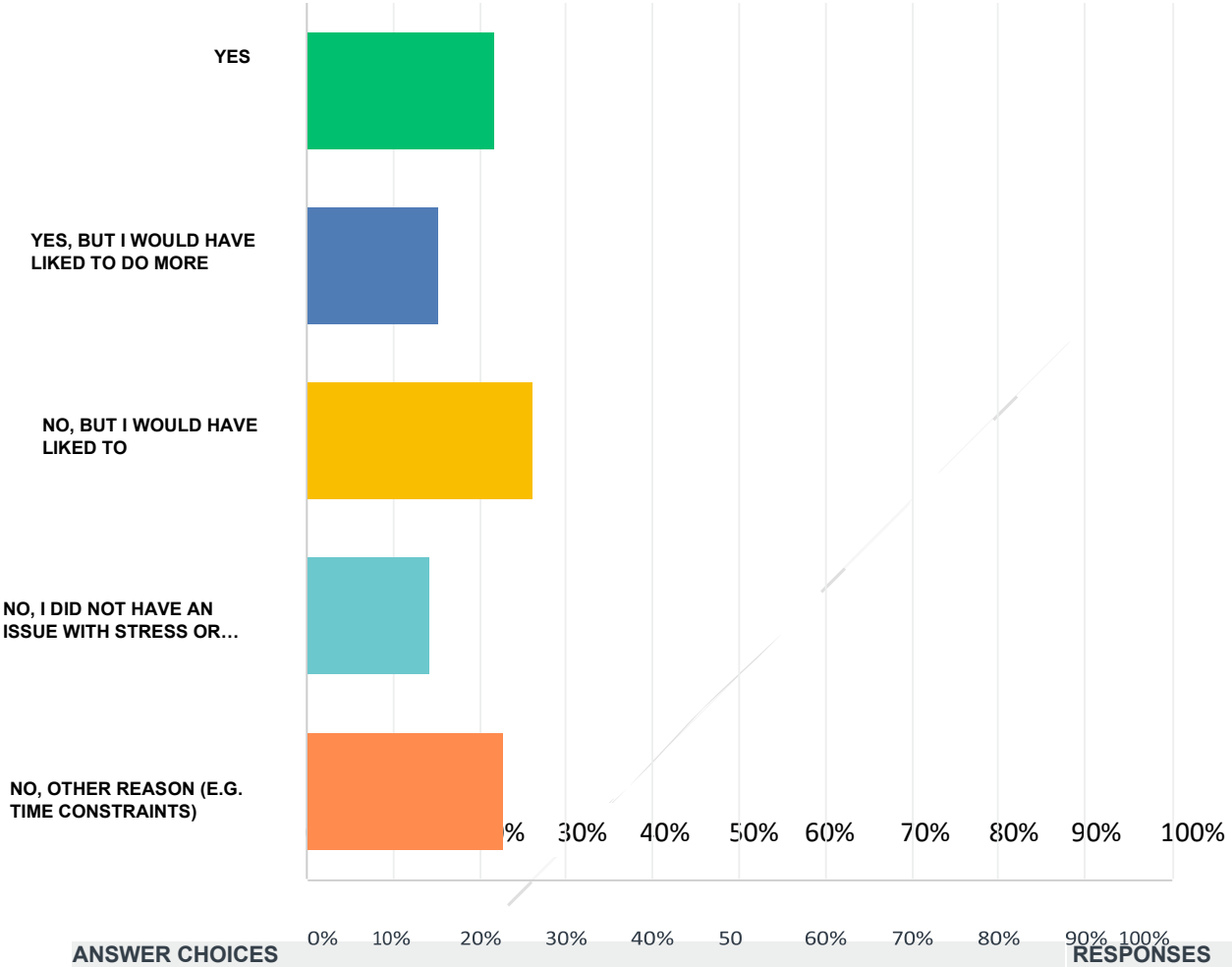
1. How satisfied are you with your current employment at PHHS?



ANSWER CHOICES	RESPONSES	
Very satisfied	43.48%	40
Satisfied	40.22%	37
Neither satisfied nor dissatisfied	11.96%	11
Dissatisfied	2.17%	2
Very dissatisfied	2.17%	2
		92

What is the story behind the curve? Goal 4 of the QIPM plan (PHHS will improve staff satisfaction scores by 10% by 10/2021.

2. **In the past year were you able to take advantage of stress-relieving activities offered by the Tribe/PHHS? Such as Cherokee Choices activities (Yoga, workout sessions, Stress/Healing Arts Retreat), break, lunchtime walking, other)**



ANSWER CHOICES	RESPONSES
Yes	(20) 21.74%
Yes, but I would have liked to do more	(14) 15.22%
No, but I would have liked to	(24) 26.09%
No, I did not have an issue with stress or I engaged in other HEALTHY stress relieving activities on my time (work out, yoga, meditate or other?	(13) 14.3%
No, other reason (e.g. time constraints)	(21) 22.83%

What is the story behind the curve?

Based on survey responses, barriers that limited participation included staffing, scheduling, and professional duties that did not allow employees to leave their duty post.

Goal 4.b. - PHHS will increase staff participation in stress relieving activities by 10% by 10/2021.

Turning the Curve

The 2020 staff satisfaction survey will explore factors that are helping and hurting employee stress, which will likely include new factors since the 2019 survey such as the COVID-19 pandemic and actions taken to support PHHS employees through the pandemic, such as:

*Remote Work Environments (access to internet, use of cell phones, adaptation to technology)

*Access to mental health and wellness services (such as the EBCI Employee Assistance Network)

*Awareness/identification of additional stress relieving activities inside/outside of the workplace

*Overall safety (potential exposure, awareness of safety measures – testing, best practices, etc)

*Child Care issues (safety risks, economic/financial uncertainty, and schedule adjustments)

Based on this survey data, PHHS will identify potential partners who may have a new role to play in improving progress (example – The Employee Assistance Program). The identification of root causes impacting progress will often point the way to the types of partners are needed. Selecting the proposed strategy involves applying four criteria to each option under the RBA framework. PHHS will choose strategies that meet 4 criteria:

1. Is the concept **specific** in nature? Does it have enough for implementation? Is there a timeline?
2. Does the strategy have **value**? Does it align with PHHS?
3. Is the strategy **within reach**? Is there a realistic budget involved?
4. Does the strategy allow **leverage** (is this concept geared to have significant impact).

Both the staff satisfaction and QI baseline surveys will be facilitated on or before 4/30/21

GETTING STARTED ON A QI PROJECT

PDCA Cycle Instructions/ worksheet (Appendix A) is available to guide staff through a QI project.

Project Identification and Selection

PHHS will complete at a minimum one (1) QI project each year. Brainstorming sessions will occur periodically throughout the year during staff meetings. Small focus groups may be used to determine QI projects. One form is required when conducting a QI project. It is the responsibility of the QIC (or project leader) to complete this form and report progress/results (QI Project Request Form Appendix G).

QI projects are selected based on data obtained from customer satisfaction surveys, event/ program evaluations, staff surveys, risk assessment, improvement plan, strategic goals, policies/ protocols, after action reports, chart audits/ compliance issues, and measures identified within the departmental performance management system.

The 2020 QIPM Plan is linked in a coordinated fashion to the 2020-2025 Strategic Plan. This will be accomplished through collaborative workforce development, customer satisfaction, data driven accountability, and established organizational culture.

Project prioritization will be based on the following criteria:

Technical:

✓Is it a process? ✓ Is data available? ✓ Is the scope manageable?
✓ Can it be completed within the proposed time frame?
✓ Can it be reliably measured?

✓ Is the problem targeted for improvement clearly defined?

Strategic:

- ✓ Is it important? To whom?
- ✓ Does it align with one or more of the department plans?
- ✓ Does the project support the department mission, vision, values?
- ✓ Does it have a customer focus?
- ✓ Does the project have potential to be replicated across programs or have an impact on other programs/ activities?

Empowerment:

- ✓ Is it within the Department's control?
- ✓ Is it free from preconceived solutions?
- ✓ Is leadership prepared to implement change?
- ✓ Is there a probability for success?

Alignment:

- ✓ Tribal Health Improvement Plan
- ✓ Strategic Plan
- ✓ Workforce Development Plan

Data Collection and Analysis

For individual projects, data will be collected and analyzed as indicated in the project plan. The QI Team leading the project will have responsibility for all aspects of the project including the collection and analysis of data. Project data will be reviewed by QI Team Leaders and QIC. Data from all projects will be collected and analyzed by using the QI Proposal Form and/or PDCA worksheet (appendices A and G) and stored on the Divisional data base. All data reporting will be distributed to the QIMDT monthly to ensure progress is being made on project goals and objectives.

QI Teams will be required to submit an updated QI Project Results Report (Appendix B) to the QIC monthly throughout the duration of the QI Project. The QI Team Leader will email the form to the QIC, who will review and forward the information to the QIMDT. Based on progress reports, the QIMDT may make recommendations or suggestions regarding the implementation of QI projects and/or determine if a performance measure issue is significant enough to warrant the implementation of a QI project.

Monitoring

The QIPM Plan will be reviewed and updated annually by the Quality Improvement Coordinator during the first quarter (January through March). Survey results from the QI Workgroups and PHHS staff will be considered during this revision process.

The QIMDT will complete an end of the Year Survey (Appendix E) that asks members to evaluate and offer feedback on the overall effectiveness of the QIPM Plan. The QIC will compile various evaluation results and draft a QI Evaluation Report. QI goals and components of the Plan will be revised as appropriate following annual review.

Lessons Learned

- ✓ Utilize resources that can provide guidance and training
- ✓ Improved training and accountability
- ✓ Provide information & clarity to staff who are unsure of what Quality Improvement is
- ✓ Provide information & clarity to staff who are unsure of what Performance Management is
- ✓ Internal and External collaboration
- ✓ Attainable timeframes

Quality Goals, Objectives & Implementation

GOAL	OBJECTIVE	ACTIVITY/MEASURE	TIME FRAME	RESPONSIBLE PARTY
Goal 1: Advance the culture of Quality Improvement within PHHS	By November 2020, develop/ establish a QI Plan that seeks to increase staff knowledge of quality improvement while considering the importance of the PHAB accreditation requirements moving forward Measure change in the Division's QI culture	A complete, published Quality Improvement Plan ready for distribution Market the importance of QI to staff: • QI Power Point presentation/training • Conduct baseline QI culture survey/orientation • Servant Leadership Performance Measures: 1. QI corner publication on line (PHHS website) PHHS workforce will complete the following: 1. baseline culture of quality survey 2. quality maturity survey 3. Succession Training	11/30/20 3/31/21 5/31/21 5/31/21	Quality Improvement Coordinator
Goal 2: Establish the Quality Improvement Multidisciplinary Team and ensure a QI tracking procedure	Develop a cross functional team from departments with the PHHS Division Create method to initiate/track QI projects	Establish monthly meetings Take minutes to document tasks, monitor progress and create data reports Develop the QI project initiation form Obtain feedback from users Use feedback to improve procedure Lead Performance Measures: QIMDT charter in place including committee members, roles, responsibilities, term limits and membership rotation. Written QI tracking Procedure/Policy Procedure Feedback results Changes to procedure if applicable	3/31/21 4/30/21	QIMDT

GOAL	OBJECTIVE	ACTIVITY/MEASURE	TIME FRAME	RESPONSIBLE PARTY
Goal 3: All leadership and staff members will actively participate in Quality Improvement activities	By May 2021, all departments will update their action plans to include participation in at least one quality improvement activity.	Complete the TRAIN network online training modules (Introduction to Quality Improvement in Public Health 1059423, Operationalizing Quality Improvement in Public Health and QI Team Development) https://www.train.org/main/course/1059243/ **or** Complete the Ohio State University College of Public Health (5 credit hours) online training modules (CQI Public Health Fundamentals, CQI Tool-Time and Public Health 101) https://osupublichealth.catalog.instructure.com The QIC will create and maintain a training log of registered staff Lead Performance Measures: Staff completion certificates or verification (goal 50% of PHHS workforce = 118)	5/31/21 5/31/21	Quality Improvement Coordinator
Goal 4: Use customer satisfaction data to inform opportunities for improvement	Conduct departmental survey to identify completed customer satisfaction surveys surveys/reports within the dept Compile/report findings customer satisfaction surveys Use results to Inform QI initiatives	Assign QIMDT member to compile and summarize survey/report data Generate a report of customer satisfaction survey/report results Disseminate report to leadership and staff to inform QI efforts Lead Performance Measure: % of customer & staff satisfaction survey data analyzed Receipt of customer service survey/report data Report of customer service survey/report data List of QI projects related to customer satisfaction data Compile list of activities related to satisfaction data (include PHHS outings & new partners)	4/30/21 5/31/21	Quality Improvement Coordinator

KEY QUALITY TERMS AND ACRONYMS

PHHS uses a common language Division-wide when communicating about culture of quality and quality improvement. Below is a list of key terms and frequently used acronyms in alphabetical order.

Accreditation: Accreditation for public health departments is defined as:

1. The development and acceptance of a set of national public health department accreditation standards;
2. The development and acceptance of a standardized process to measure health department performance against those standards;
3. The periodic issuance of recognition for health departments that meet a specified set of national accreditation standards; and
4. The periodic review, refining, and updating of the national public health department accreditation standards and the process for measuring and awarding accreditation recognition. (Public Health Accreditation Board. *Guide to National Public Health Department Accreditation Version 1.0.* Alexandria, VA. May 2011).

Accreditation Coordinator (AC): The person responsible for coordinating the application and accreditation process within the health department. The Accreditation Coordinator is the primary point of communication with the Public Health Accreditation Board staff during the accreditation process. (Public Health Accreditation Board. *Guide to National Public Health Department Accreditation Version 1.0.* Alexandria, VA, May 2011).

Aim Statement: A concise, specific written statement that defines what the team hopes to accomplish with its QI efforts. Aim statement may also be referred to as a QA indicator

Baseline: A quantitative level of performance which defines where the PM measure or QI indicator is currently. This number is used to measure progress or lack thereof. Baseline may also be referred to as status.

Cherokee Health System: The EBCI-based integrated Tribal community health system that spans the spectrum of clinical care, behavioral health, public health, and human services.

Continuous Quality Improvement (CQI): A systematic, department-wide approach for achieving measurable improvements in the efficiency, effectiveness, performance, accountability, and outcomes of the processes or services provided. Applies use of a formal process (PDSA, etc.) to "dissect" a problem, discover a root cause, implement a solution, measure success/failures, and/or sustain gains.

Cultural Competence: A set of skills that result in an individual understanding and appreciating cultural differences and similarities within, among, and between groups and individuals. This competence requires that the draw on the community-based values, traditions, and customs to work with knowledgeable persons of and from the community developing targeted interventions and communications. (National Public Health Performance Standards Program, *Acronyms, Glossary, and Reference Terms*, CDC, 2007. www.cdc.gov/nphpsp/PDF/Glossary.pdf

Customer/Client Satisfaction: The degree of satisfaction provided by a person or group receiving a service, as defined by that person or group. (www.businessdictionary.com/definition/customer-satisfaction.html)

Dashboard: information management tool tool that visually tracks, analyzes and displays key performance indicators (also referred to as a scorecard). (Klipfolio 2020 Inc).

Essential Public Health Services: The ten services identified in *Public Health in America* developed by representatives from federal agencies and national organizations to describe what public health seeks to accomplish and how it will carry out its basic responsibilities. These ten services define the practice of public health:

1. Assess and monitor population health status, factors that influence health, and community needs and assets
2. Investigate, diagnose, and address health problems and hazards affecting the population
3. Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it
4. Strengthen, support, and mobilize communities and partnerships to improve health
5. Create, champion, and implement policies, plans, and laws that impact health
6. Utilize legal and regulatory actions designed to improve and protect the public's health
7. Assure an effective system that enables equitable access to the individual services and care needed to be healthy
8. Build and support a diverse and skilled public health workforce
9. Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement
10. Build and maintain a strong organizational infrastructure for public health

Goal: Desired result to be accomplished. In QI, goal may also be referred to a target. In a PM system, goals identify the desired result i.e. community members will be

healthy. In a PM system, goals typically have one or more objectives to be achieved within a more or less fixed timeframe.

Health Disparities: Differences in population health status that are avoidable and can be changed. These differences can result from environmental**,** social and/or economic conditions, as well as public policy. These and other factors adversely affect population health. (NACCHO. *Operational Definition of a Functional Local Health Department.* November 2005).

Health Equity: Attainment of the highest level of health for all people. Health equity means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives. (Healthy People 2020)

Indicator: In QI, this is a measurable variable used as a representation of an associated factor or quantity. In a PM system an indicator would be part of an objective to obtain a goal.

Kaizen: Kaizen is the practice of continuous improvement. Kaizen was originally introduced to the West by Masaaki Imai in his book *Kaizen: The Key to Japan's Competitive Success* in 1986. Today Kaizen is recognized worldwide as an important pillar of an organization's long-term competitive strategy. Kaizen is continuous improvement that is based on certain guiding principles. Common Kaizen principles involve taking action to contain root causes of problems, speaking with data while managing with facts, using teamwork, and better understanding the situation by seeing the issue yourself. Good processes bring good results. By implementing systematic change, notable outcomes can be universally achieved. One of the most notable features of kaizen is that big results come from many small changes accumulated over time. However, this has been misunderstood to mean that kaizen equals small changes. In fact, kaizen means everyone involved in making improvements. While the majority of changes may be small, the greatest impact may be kaizens that are led by senior management as transformational projects, or by cross-functional teams as kaizen events. www.kaizen.com)

MAPP: Mobilizing for Action through Planning and Partnerships, which PHHS has adopted as the framework for our THA and THIP processes

NACCHO: National Association of County and City Health Officials

NIHB: National Indian Health Board

NNPHI: National Network of Public Health Institutes

National Public Health Improvement Initiative (NPHII): An initiative, managed by the Office for State, Tribal, Local and Territorial Support (OSTLTS) at CDC, is intended to strengthen public health infrastructure and systematically increase performance management capacity so that public health goals are effectively and efficiently met. NPHII is part of the Prevention and Public Health Fund of the Affordable Care Act of 2010. (www.cdc.gov/ostlts/nphii)

National Public Health Performance Standards Program (NPHPSP): A collaborative effort to enhance the Nation's public health systems. The stated mission and goals of the NPHPSP are to improve the quality of public health practice and the performance of public health systems by providing performance standards for public health systems and encouraging their widespread use; encouraging and leveraging national, state, and local partnerships to build a stronger foundation for public health preparedness; promoting continuous quality improvement of public health systems; and, strengthening the science base for public health practice improvement.

Objective: A statement identifying a specific indicator to measure progress toward a goal with its performance management system. Objectives should be written SMART.

Outcome: determination and evaluation of the results of an activity, plan, process or program and their comparison with the intended or projected results. In QI, outcome may be used to describe results of the QI project when comparing actual results to the set target/ goal. In a PM system, outcome may be used to describe results of progress toward set performance measures as well as progress toward established goals.

Performance Standard: A generally accepted, objective standard of performance such as a rule or guideline against which an organization's level of performance can be compared. WI 2020 Health Priorities or PHAB standards are examples. These may or may not be stated in quantitative terms.

Performance Measure: A quantitative indicator of performance that can be used to show progress toward a goal or objective. It is the specific number representation of a capacity, process, or outcome that is relevant to the assessment of performance. Sometimes performance measures are confused with objectives. For our purposes, when we talk about performance measures, we are only referring to what is being measured, not the entire SMART objective.

Performance Management (PM) System: Identifies actual results against planned or intended results. Performance management systems ensure that progress is being made toward department goals by systematically collecting and analyzing data to track results to identify opportunities and targets for improvement. This differs from Quality Improvement as QI simply examines processes in order to improve them. PM addresses human performance within organizations at the individual, process and organizational level. To better understand this distinction reference the models below: (Public Health Accreditation Board. *Standards and Measures Version 1.5.* Alexandria, VA, December 2013, QI and PI Different Means to the Same End, Thada Bornstein, 2020)

PHAB: Public Health Accreditation Board

Plan, Do, Study, Act (PDSA, also known as Plan-Do-Check-Act): An iterative, four-stage, problem-solving model for improving a process or carrying out change. PDSA stems from the scientific

method (hypothesize, experiment, evaluate). A fundamental principle of PDSA is iteration. Once a hypothesis is supported or negated, executing the cycle again will extend what one has learned. (Embracing Quality in Local Public Health: Michigan's QI Guidebook, 2008).

Population Health: A cohesive, integrated and comprehensive approach to health considering the distribution of health outcomes within a population, the health determinants that influence the distribution of care, and the policies and interventions that impact and are impacted by the determinants. (Nash, Reifsnyder, Fabius, and Pracilio. Population Health: Creating a Culture of Quality 2013).

Practice-based Evidence: For Tribal health departments, for the purposes of PHAB accreditation, practice-based evidence is the incorporation of evidence grounded in cultural values, beliefs, and traditional practices. (Public Health Accreditation Board. *Standards and Measures Version 1.0.* Alexandria, VA, May 2011).

PHF: Public Health Foundation

Public Health Surveillance: The continuous, systematic collection, analysis, and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice. (World Health Organization. *Health Topics: Public Health Surveillance)*

Quality Culture: QI is fully embedded into the way the agency does business, across all levels, departments, and programs. Leadership and staff are fully committed to quality, and results of QI efforts are communicated internally and externally. Even if leadership changes, the basics of QI are so ingrained in staff that they seek out the root cause of problems. They do not assume that an intervention will be effective, but rather they establish and quantify progress toward measurable objectives. (Roadmap to a Culture of Quality Improvement, NACCHO, 2012).

Quality Improvement (QI): The use of a deliberate and defined improvement process, such as Plan-Do-Study-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community. (Riley, Moran, Corso, Beitsch, Bialek, and Cofsky. Defining Quality Improvement in Public Health. Journal of Public Health Management and Practice. January/February 2010).

Quality Improvement Multidisciplinary Team (QIMDT): A team of individuals assembled from different professional disciplines/backgrounds that contribute to a project, goal or purpose.

Quality Improvement Plan: A plan that identifies specific areas of current operational performance for improvement within the agency. These plans can and should cross-reference

one another, so a quality improvement initiative that is in the QI Plan may also be in the Strategic Plan. (PHAB Acronyms and Glossary 2009).

Results-Based Accountability (RBA)™: A disciplined way of thinking and acting to improve entrenched and complex social problems. Communities use it to improve the lives of children, youth, families, adults. RBA is also used by organizations to improve the effectiveness of their programs…. RBA uses a data-driven, decision-making process to help communities and organizations get beyond talking about problems to taking action to solve problems. It is a simple, common sense framework that everyone can understand. RBA starts with ends and works backward, towards means. The "end" or difference you are trying to make looks slightly different if you are working on a broad community level or are focusing on your specific program or organization….The population versus performance distinction is what separates RBA from all other frameworks. It is important to understand because it determines who is responsible for what. Population accountability organizes our work with co-equal partners to promote community well-being. In contrast, Performance Accountability organizes our work to have the greatest impact on our customers. (Clear Impact, https://clearimpact.com/results-based-accountability/#content).

Servant Leadership: a leadership philosophy in which the main goal of the leader is to serve. This is different from traditional leadership where the leader's main focus is the thriving of their company or organizations. A Servant Leader shares power, puts the needs of the employees first and helps people develop and perform as highly as possible. Servant leadership inverts the norm, which puts the customer service associates as a main priority

Scorecard: (also referred to as "dashboard") Visual depiction of data and trends in reference to goals, objectives, results, indicators, and/ or performance measures.

SMART: Specific, Measurable, Achievable, Relevant, and Time-bound. For example, "By January 15, 2021, food service workers from restaurants will demonstrate a 20% increase in the ServSafe exam passing rate."

Status: In a QI project, where the indicator is at currently. Status may also be referred to as baseline.

Target: the quantifiable amount of improvement to be achieved. For example, "from 85% to 95% of children receive... ". In QI, target may also be referred to as a goal.

Storyboard: Graphic representation of a QI team's quality improvement journey. (Scamarcia-Tews, Heany, Jones, VanDerMoere & Madamala, 2012).

Staff satisfaction: The degree of satisfaction the staff experiences in the course of providing services and working within an organization.

Strategic Plan: An organizational plan that results from a deliberate decision-making process and defines where an organization is going. The plan sets the direction for the organization and, through a common understanding of the mission, vision, goals, and objectives, provides a template for all employees and stakeholders to make decisions that move the organization forward. The strategic plan must include an implementation plan and monitoring of goals and objectives. (Adapted from Swayne, Duncan, and Ginter. Strategic Management of Health Care Organizations. New Jersey 2011).

Training: The provision of information and professional and skill development through a variety of formal, regular, planned means to support the workforce in maintaining the skills, competencies, and knowledge needed to successfully perform their duties. (*Who Will Keep the Public Healthy?* National Academies Press. Washington, DC, 2003).

Trend Analysis: A study design which focuses on overall patterns of change in an indicator over time, comparing one time period with another time period for that indicator. Trend analysis is not used to determine causation but rather to draw associations and track progress. Trend analysis is commonly used in program evaluation, for policy analysis, and for etiologic analysis. (Adapted from Nash, Reifsnyder, Fabius, and Pracilio. Jones and Bartlett. MA, 2011).

TPHAAB: Tribal Public Health Accreditation Advisory Board, a committee of NIHB that addresses public health accreditation in Indian Country.

Tribal Health Assessment (THA): A periodic, systematic examination of the health status indicators for the Tribal community that is used to identify key community issues and assets. In EBCI, the goal of the THA is to develop strategies to address the community's health needs and identified issues. Tools and processes in conducting the THA include data gathering and analysis, community engagement, and collaborative participation.

Tribal Health Improvement Plan/ Process (THIP): A long-term, cyclic, systematic effort led by PHHS to address public health problems based on the results of Tribal health assessment activities and the community health improvement process. This plan is shared by the Cherokee Health System and other EBCI community partners to set priorities, coordinate and target resources, develop policies, and define actions to target efforts that promote health. It describes the vision for the health of the EBCI community through a collaborative process and addresses the gamut of community and organizational strengths, weaknesses, opportunities, and threats. The THA and THIP are components of a community-wide QI process. (Adapted from: United States Department of Health and Human Services, *Healthy People 2010.* Washington, DC)

Tribal Health Board: The governing body of EBCI PHHS, which comprises members of Tribal Council, Cherokee Health System representatives, and community members.

Tribal Health Department: An agency of a federally recognized Tribal government, Tribal organization or inter-Tribal consortium, as defined in the Indian Self-Determination

and Education Assistance Act, as amended. Such departments have jurisdictional authority to provide public health services, as evidenced by constitution, resolution, ordinance, executive order or other legal means, intended to promote and protect the Tribe's overall health, wellness and safety; prevent disease; and respond to issues and events. Federally recognized Tribal governments may carry out the above public health functions in a cooperative manner through formal agreement, formal partnership or formal collaboration.

(Public Health Accreditation Board. *Guide to National Public Health Department Accreditation Version 1.0.* Alexandria, VA, May 2011).

Workforce Development Plan: PHHS plan that focuses on the alignment of workforce development with the health department's overall mission and goals and the development of strategies for acquiring, developing, and retaining staff. Additionally this plan identifies gaps in employee knowledge, skills, and abilities through the assessment of both organizational and individual needs, and addressing those gaps through targeted training and development opportunities.

RECOGNITION & REFERENCES

Recognition

Forest County Potawatomi Community Health Department Quality Improvement Plan 2015-2017

References

American Society for Quality, http://asq.org/index.aspx

Embracing Quality in Local Public Health; Michigan's Quality Improvement Guide Bookhttp://accreditation.localhealth.net

Institute for Healthcare Improvement
http://www.ihi.org/resources/Pages/AudioandVideo/default.aspx

Institute for Wisconsin's Health Public Health Quality Initiative
http://www.instituteforwihealth.org/public-health-quality.html

Oneida Comprehensive Health Division Quality Improvement Committee/ Plan

QI training: "Embracing Quality in Public Health: A Practitioner's Performance Management Primer" http://mphiaccredandqi.org/PMQlTraining/

PPENDICES

Appendix A: PHHS QI Process PLAN-DO-CHECK-ACT (PDCA) 032321

Instructions/ Worksheet

Steps of the PDCA Cycle		
PLAN	Step 1	Identify the problem/ QI project 1. How does the project support our mission, vision or strategic directions? 2. Who are our stakeholders (internal/ external) and what are their concerns? 3. What resources/ support will be needed? 4. What potential impact could there be on other programs/ activities if this QI is conducted?
	Step 2	Assemble a workgroup Who will participate in the QI project? Who is the project leader on the QI project?
	Step 3	Background/ research What existing data is there? What might be the root cause of the problem? Can You map out the process?
	Step 4	Brainstorm solutions What are some possible solutions?
	Step 5	Develop a theory of improvement- select one solution to test What one possible solution will you test? What is our hunch/ prediction? (if we do this... , then that will happen)
		Develop Aim Statement- SMART when possible 1. What are we trying to accomplish? 2. How will we know that a change is an improvement? 3. What changes can we make that will result in improvement?
DO	Step 6	Collect data- test your improvement theory 1. Create & implement small scale test of change to process. 2. Collect, chart & display data 3. Document problems, unexpected observations & side effects
CHECK	Step 7	Study the results of your test. l. Did your test work? How do you know? 2. Did the results match your theory? What does your data show? 3. Are there trends in your data? 4. Did you have unintended side effects?

		5. Is there improvement? 6. Do you need to test the improvement under other conditions?
ACT	Step 8	Standardize OR develop a new theory What actions will take place as a result of the QI project? Will you need to educate staff on changes? Will you need to u date SOPs or Procedures?
	tep 9	Establish future plans Is there a need to retest down the road i.e. in 6 months? Will you expand the study to another department/team

QA Indicator	Criteria	Status	Goal	Timeline	Total	Actual	Action	Foll
Measurable variable used as a representation of an associated factor or quantity.	Specific data to be evaluated	Current Measure	Desired Measure	Evaluation period	# evaluated	# of criteria met	Resulting actions	Fut pla
Plan				**Do**		**Check**	**Act**	

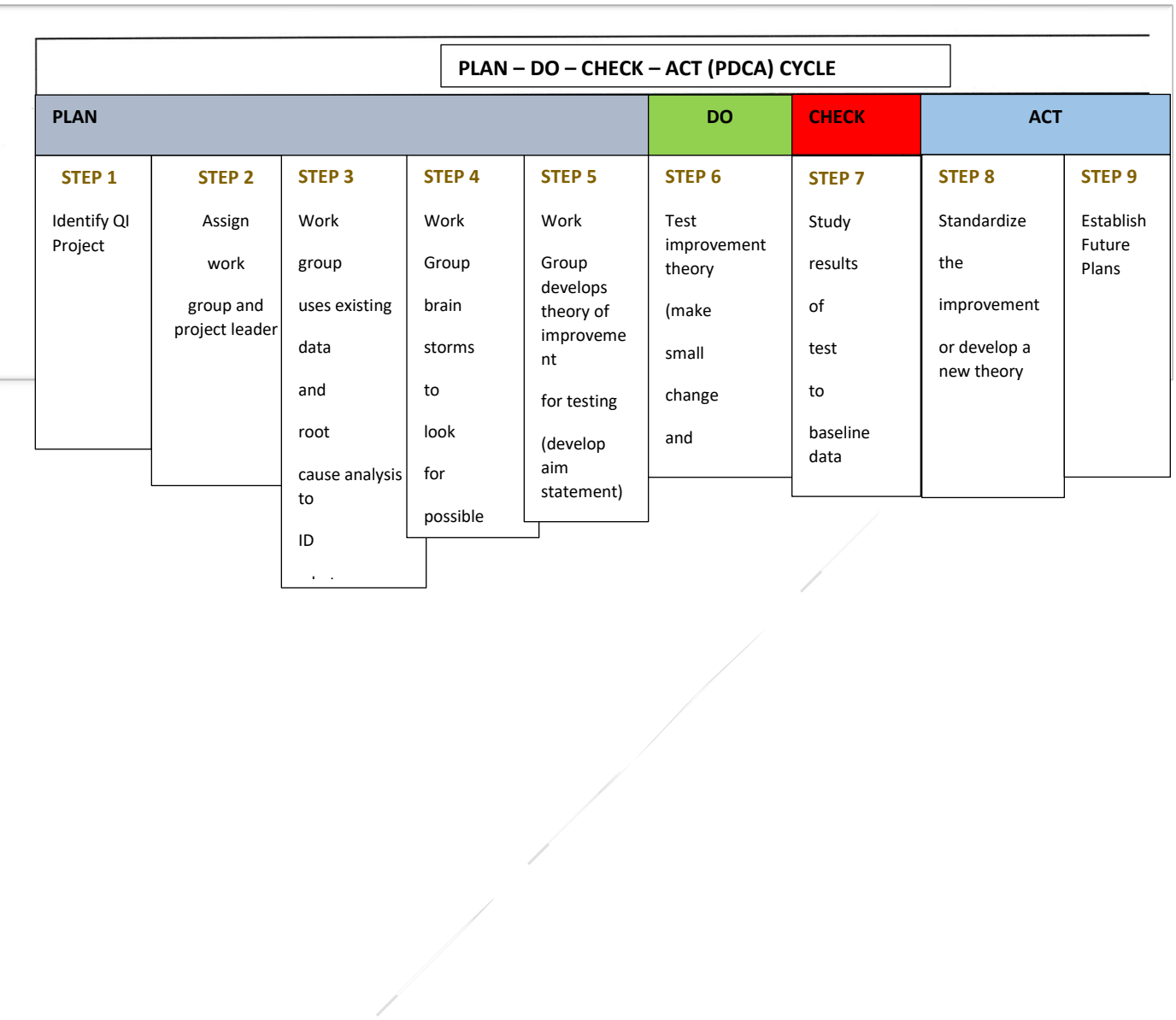
Example 1

QA Indicator	Criteria	Status	Goal	Timeline	Total	Actual	Action	Follow up
Number of employees with successful completion of QI training modules	Observe/ Verify certificates obtained	Collecting Baseline	100%	12/31/2020 - 02/28/2021	12	12 (100 %)	Resulting actions	Future plans
Plan				**Do**		**Check**	**Act**	

Example 2

QA Indicator SMART	Criteria	Status	Goal	Timeline	Total	Actual	Action	Follow up
By 3/1/21 PHHS employees will demonstrate a 25% increase in overall scoring of culture of quality survey	Evaluate data from 11/1/20– 12/31/20 Compare scoring with data from 1/1/21 – 3/1/21	50%	75%	11/1/2020 – 3/1/2021	Average of 4 per month (=16)	16 (75 %)	Continue Training	Repeat QI in 3 months
Plan				**Do**		**Check**	**Act**	

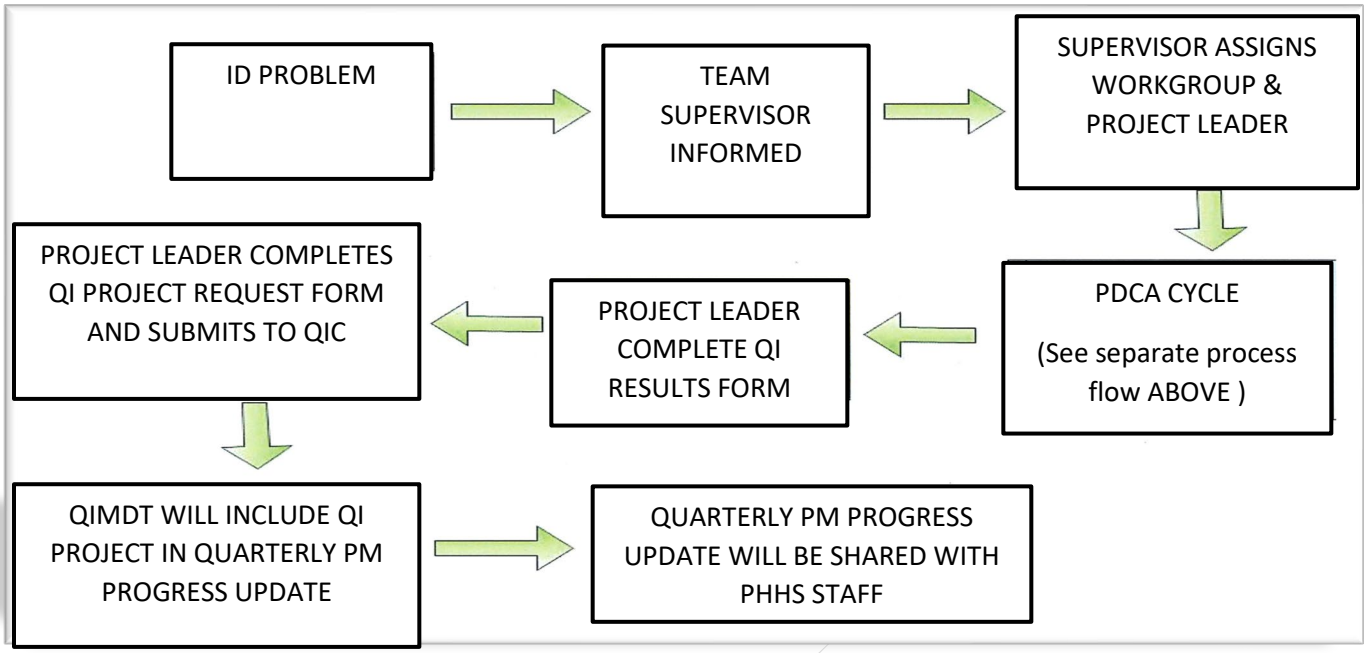
Appendix C: EBCI Public Health and Human Services PDCA CYCLE 3/23/21



*Printed copies are for reference only. Please refer to electronic copy or divisional policy manual for updated version.

Appendix D:

EBCI Public Health and Human Services Quality Improvement Process updated 3/23/21



EBCI Public Health and Human Services

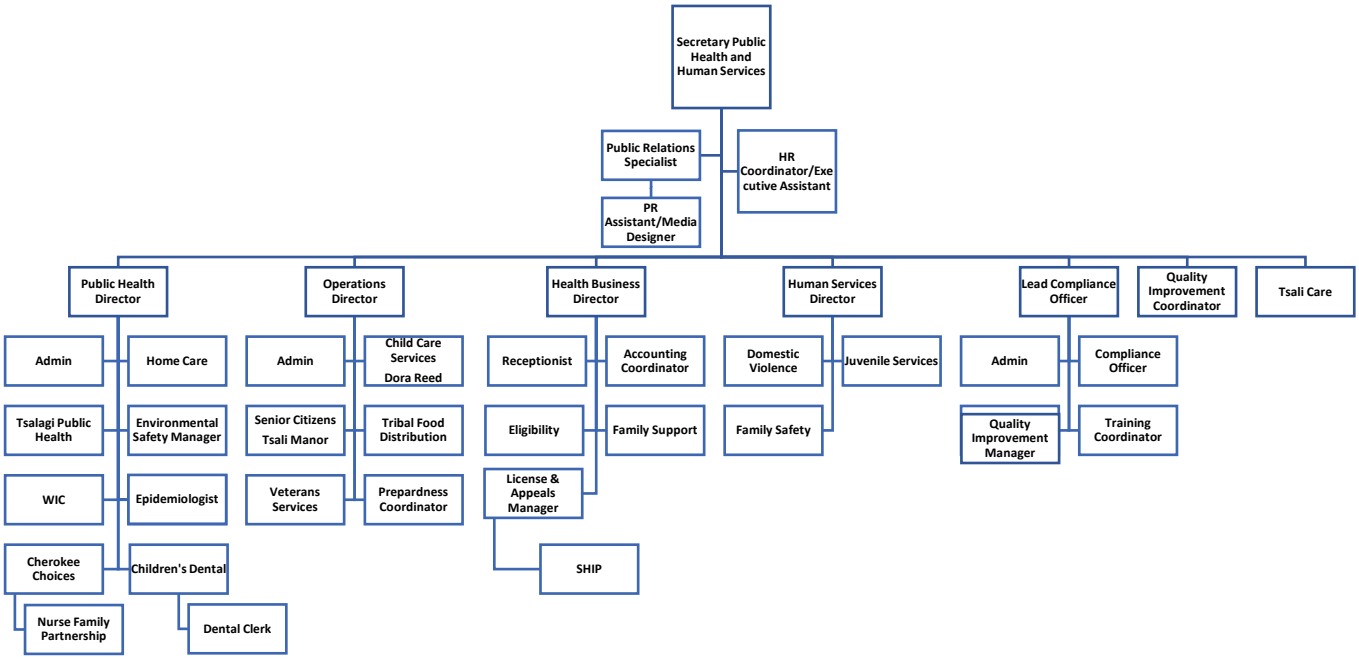
Plan Evaluation Survey information updated 3/23/21

Appendix E: PHHS Staff Survey

The survey will ask staff to share feedback on their experiences with QI projects, including department strengths and weaknesses, QI barriers, training needs, confidence in leading QI projects, comfort in using QI tools/forms and understanding of the PHHS QIPM Plan and concepts. This survey will also gather information for future QI projects.

1. Have you reviewed with PHHS Quality Improvement Performance Management Plan?
2. Level of understanding of performance management?
3. What parts of the QIPM plan do you not understand?
4. Did you participate in a QI project this year?
5. If yes, (list a brief description and feedback here)

Appendix F: 2019 PHHS Organizational Chart



*Printed copies are for reference only. Please refer to electronic copy or divisional policy manual for updated version.

Appendix G: QI Project Proposal Form

Project Name: 1-3 word Identifier	**Sponsor(s):** Who is governing and resourcing this project? (Division, program)
Problem/Opportunity: 1-3 sentences describing the problem/opportunity (without assumption of cause or solution) and why it is important (impact on program or division/agency strategic goals)	
Type of Problem/Opportunity: □ QI Process Action Team □ QI Process Improvement □ QI/Preparedness collaboration	
Overall Objective: 1 sentence declaration as to what the project team is to do without assumption of cause or solution. (a.k.a. mission statement, purpose statement, etc.) Remember S.M.A.R.T. = direction + measure/what you are improving + target + timeframe	
Performance Measure (s): The quantitative indicator(s) which demonstrate performance had improved. More than 2-3 measures may indicate lack of focus (i.e., %, number, count, average, etc.)	**Target(s):** How much improvement is expected/hoped for?
Strategic Plan Objective (if applicable):	**RBA Measure (if applicable):**
Team Leader:	**Team Facilitator:**
Team Members: Who will be active participants on the project team? Ensure representative of process steps and other key stakeholders? (For projects of smaller scope, you may not have team members other than lead and/or process owner)	
Constraints: Are there time, space, financial, system, policy, organizational or other constraints that the team leader and members should be aware of?	**Resource Requirements:** What resources are available to the team to support completion of its mission? (time, IT, budget, staff support etc.)
How do you think you will proceed with analyzing this problem for root cause or customer need?	
Target Start Date:	**Target End Date:**
Who will be primarily responsible for maintaining process performance after completion of the project?	

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DIVISIONAL POLICY AND PROCEDURES

FORMS

REQUEST FOR ADMINISTRATIVE LEAVE FOR TRIBAL EMPLOYEES FORM

Name of Program making request

Activity Planned:

Date of Activity:

Location of Activity:

Amount of time requested:

Contact person:

Other resources needed:

JUSTIFICATION

Target Population:

Objective:

Summary of Project:

Benefits to Patients/Employees:

Why can this activity not be conducted after work hours?

For Administrative Use

APPROVAL / DISAPPROVAL

Public Health and Human Services (PHHS) Administrative staff met on _____ to discuss your Administrative leave request.

_____Your request was **APPROVED** by PHHS Administration and will be forwarded on the EBCI Executive Committee for final approval.

_____Your request was **DENIED** due to the following reasons:

↑ 1. This activity could be held after 4:30.

↑ 2. Excessive number of requests this year.

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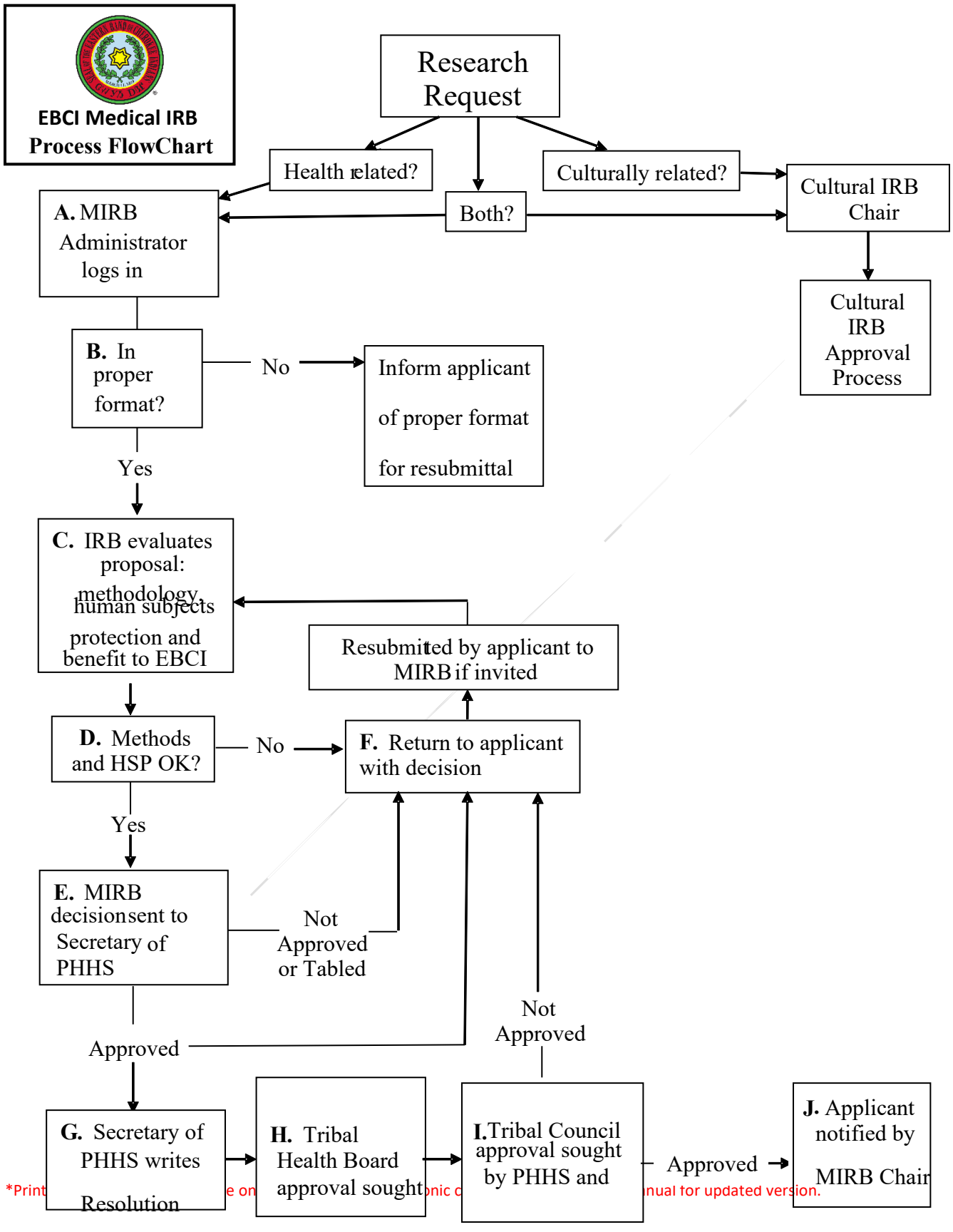

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DIVISIONAL POLICY AND PROCEDURES

REFUSAL FOR INFLUENZA VACCINE
DECLINATION FOR INFLUENZA VACCINE

I choose not to receive the vaccine because:

___I have already received the flu vaccine: When_____Where_____

___Medication contraindication

___Fear of needles

___Fear of vaccines

___Never had the flu

___I am afraid it will make me sick

___Concern about possible side effects

___Don't believe it is important to be vaccinated for the flu

___I am pregnant and want to discuss this with my doctor (you can receive flu vaccine during pregnancy)

___I do not want to receive the vaccine

___Inconvenient (if so, please explain how we can improve this service for you)

___Prior reaction to the flu vaccine

___Prefer not to answer

By signing this below, I acknowledge that I have been offered the vaccine and have chosen to decline the vaccination.

Signature_____Date_____

Print Name_____

Chart number_____Birthdate_____

I understand that I can change my mind later and get the vaccination. I also understand I am not required as a part of my employment to be vaccinated against influenza.

*Printed copies are for reference only. Please refer to electronic copy or divisional policy manual for updated version.

DIVISIONAL POLICY AND PROCEDURES

BUILDING/DOOR KEY REQUEST FORM

To receive a door key, you must complete this form and return to the PHHS Operations Director or Designee. Department administrator or manager must sign this form.

EMPLOYEE INFORMATION

First Name	Middle Name	Last Name

Employee Position Title	Employee Number	Employee Phone Number

BUILDING INFORMATION & ACCESS AREA REQUESTED

Building Name	Physical Address

Times	Other Specified Doors

Dates and Times Requesting Entry	Specified Doors

Authorized Building Administrator/Manager Name: Title: Date:

Agreement: This key is the property of the EBCI and is for the exclusive use of the person to whom it is issued. The Key holder is subject to the rules and regulations of the issuing Department. The key must be returned to the EBCI/Division at the end of the employment or at the request of the Building Manager. Failure to comply with these rules may result in the loss of access privileges and/or termination. **Lost or Stolen Keys must be reported immediately.** A fee may be assessed before another key can be issued.

Keyholder's Signature: _____ Date: _____

Key issued by: _____ Date: _____

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