

those furnished through agreement or arrangement.

(ii) Guidelines for the medical management of health problems which include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services furnished by the clinic or center.

(iii) Rules for the storage, handling, and administration of drugs and biologicals.

(4) These policies are reviewed at least annually by the group of professional personnel required under paragraph (b)(2) of this section and reviewed as necessary by the clinic or center.

(c) *Direct services*—(1) *General*. The clinic or center staff furnishes those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at the entry point into the health care delivery system. These include medical history, physical examination, assessment of health status, and treatment for a variety of medical conditions.

(2) *Laboratory*. These requirements apply to RHCs but not to FQHCs. The RHC provides laboratory services in accordance with part 493 of this chapter, which implements the provisions of section 353 of the Public Health Service Act. The RHC provides basic laboratory services essential to the immediate diagnosis and treatment of the patient, including:

(i) Chemical examinations of urine by stick or tablet method or both (including urine ketones);

(ii) Hemoglobin or hematocrit;

(iii) Blood glucose;

(iv) Examination of stool specimens for occult blood;

(v) Pregnancy tests; and

(vi) Primary culturing for transmittal to a certified laboratory.

(3) *Emergency*. The clinic or center provides medical emergency procedures as a first response to common life-threatening injuries and acute illness and has available the drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids.

(d) *Services provided through agreements or arrangements*. (1) The clinic or center has agreements or arrangements with one or more providers or suppliers participating under Medicare or Medicaid to furnish other services to its patients, including:

(i) Inpatient hospital care;

(ii) Physician(s) services (whether furnished in the hospital, the office, the patient's home, a skilled nursing facility, or elsewhere); and

(iii) Additional and specialized diagnostic and laboratory services that are not available at the clinic or center.

(2) If the agreements are not in writing, there is evidence that patients referred by the clinic or center are being accepted and treated.

[57 FR 24983, June 12, 1992, as amended at 58 FR 63536, Dec. 2, 1993]

§ 491.10 Patient health records.

(a) *Records system*. (1) The clinic or center maintains a clinical record system in accordance with written policies and procedures.

(2) A designated member of the professional staff is responsible for maintaining the records and for insuring that they are completely and accurately documented, readily accessible, and systematically organized.

(3) For each patient receiving health care services, the clinic or center maintains a record that includes, as applicable:

(i) Identification and social data, evidence of consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;

(ii) Reports of physical examinations, diagnostic and laboratory test results, and consultative findings;

(iii) All physician's orders, reports of treatments and medications, and other pertinent information necessary to monitor the patient's progress;

(iv) Signatures of the physician or other health care professional.

(b) *Protection of record information*. (1) The clinic or center maintains the confidentiality of record information and provides safeguards against loss, destruction or unauthorized use.

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(2) Written policies and procedures govern the use and removal of records from the clinic or center and the conditions for release of information.

(3) The patient's written consent is required for release of information not authorized to be released without such consent.

(c) *Retention of records.* The records are retained for at least 6 years from date of last entry, and longer if required by State statute.

(Secs. 1102, 1833 and 1902(a)(13), Social Security Act; 49 Stat. 647, 91 Stat. 1485 (42 U.S.C. 1302, 13951 and 1396a(a)(13)))

[43 FR 30529, July 14, 1978. Redesignated at 50 FR 33034, Aug. 16, 1985, as amended at 57 FR 24984, June 12, 1992]

§ 491.11 Quality assessment and performance improvement.

The RHC must develop, implement, evaluate, and maintain an effective, ongoing, data-driven quality assessment and performance improvement (QAPI) program. The self-assessment and performance improvement program must be appropriate for the complexity of the RHC's organization and services and focus on maximizing outcomes by improving patient safety, quality of care, and patient satisfaction.

(a) *Standard: Components of a QAPI program.* The RHC's QAPI program must include, but not be limited to, the use of objective measures to evaluate the following:

(1) Organizational processes, functions, and services.

(2) Utilization of clinic services, including at least the number of patients served and the volume of services.

(b) *Standard: Program activities.* (1) For each of the areas listed in paragraph (a)(1) of this section, the RHC must do the following:

(i) Adopt or develop performance measures that reflect processes of care and RHC operation and is shown to be predictive of desired patient outcomes or be the outcomes themselves.

(ii) Use the measures to analyze and track its performance.

(2) The RHC must set priorities for performance improvement, considering either high-volume, high-risk services, the care of acute and chronic conditions, patient safety, coordination of

care, convenience and timeliness of available services, or grievances and complaints.

(3) The RHC must conduct distinct improvement projects; the number and frequency of distinct improvement projects conducted by the RHC must reflect the scope and complexity of the clinic's services and available resources.

(4) The RHC must maintain records on its QAPI program and quality improvement projects.

(5) An RHC may undertake a program to develop and implement an information technology system explicitly designed to improve patient safety and quality of care. This activity will be considered to fulfill the requirement for a project under this section.

(c) *Standard: Program responsibilities.* The RHC's professional staff, administrative officials, and governing body (if applicable) are responsible for the following:

(1) Ensuring that quality assessment and performance improvement efforts effectively address identified priorities.

(2) Identifying or approving those priorities and for the development, implementation, and evaluation of improvement actions.

[68 FR 74817, Dec. 24, 2003]

PART 493—LABORATORY REQUIREMENTS

Subpart A—General Provisions

- Sec. 493.1 Basis and scope. 493.2 Definitions. 493.3 Applicability. 493.5 Categories of tests by complexity. 493.15 Laboratories performing waived tests. 493.17 Test categorization. 493.19 Provider-performed microscopy (PPM) procedures. 493.20 Laboratories performing tests of moderate complexity. 493.25 Laboratories performing tests of high complexity.

Subpart B—Certificate of Waiver

- 493.35 Application for a certificate of waiver. 493.37 Requirements for a certificate of waiver.