

Occupy Medical Policies and Procedures

Vision

Health care is a human right.

Mission

- Our primary concern is delivering excellent, timely, and appropriate medical care in a variety of settings, including Occupy encampments, demonstrations, and in the street Clinic.
- We additionally provide health-related outreach, empowerment, and education in the context of the greater Occupy movement.

Governance

- Occupy Medical is a loosely organized group with flexible membership. Member status, orientation procedures, decisionmaking processes, and other details of governance may be changed as needed by the group.
- Currently, decisions concerning Occupy Medical activities, facilities, and properties are decided by consensus of a quorum of at least five "core" group members.
- "Core" group status is attained by formal Orientation and attendance at three group meetings, after which a member may be added to the core group by a consensus process vote and may then may participate in quorum consensus decisionmaking.
- Policy changes resulting from quorum consensus process are announced in meeting minutes published on the website.
- Members may withdraw from the group by publicly announcing their intention to do so, as enumerated in the Orientation procedure.
- All Occupy Medical properties, facilities, and documents are owned in common by Occupy Medical and are not for loan, resale, or repurposing without quorum consensus.

Finances

- Financial decisions are made by quorum consensus decisionmaking, and carried out by two of three bank-account officials, also chosen by consensus.
- Grant monies and tax-deduction-eligible donations may be administered by outside agencies, as determined by group consensus.

Personnel

- Clinic care providers: doctors, nurses, bodyworkers, pharmacists, herbalists, midwives, and other alternative treatment providers. Psychologists, counselors, therapists, social workers, substance counselors, and other psychosocial care providers. Students of all these helping professions, supervised directly by appropriate care providers.
- Clinic support staff: group and clinic management, financial administration, medical records, public and press liaisons, security, engineering, and facilities maintenance.

Training/Orientation

- Each practitioner providing direct patient care is oriented and vouched for by a "core" group member who serves as their primary "back-up" contact. See Orientation procedure for details.
- Each practitioner providing direct patient care provides a physical copy of their current or most recent credentials/qualifications to be stored at the clinic and displayed when they provide care.
- Care providers have the option of obtaining Oregon State liability protection under the "Good Samaritan" law as detailed in the Orientation procedure.
- Each practitioner providing direct patient care is encouraged to attend group meetings and participate in the quorum consensus decisionmaking process.
- Training for support staff positions is provided by individuals knowledgeable in particular work areas.

Communications

- Group communications are conducted by means of the group website, to which "core" members have administrative and editorial access, as well as via an email mailing list and a closed (private) Facebook group. Members without access to electronic communications may be contacted by phone and may attend group meetings. The Orientation process, which establishes close "back-up" relations, also facilitates group communications in the absence of electronic communications.

- Communications follow four main "streams":
 1. Public communications, conducted via public appearances, online and published announcements, press releases, etc.
 2. Group communications, conducted at meetings, in clinic, and online.
 3. "Station" communications, conducted between one "station coordinator" and the other workers in their station. Example: One nurse coordinates staffing of the Nurse station for the upcoming clinic, or delegates the staffing to another member. That nurse is the contact "point person" to call in case of staffing problems.
 4. Individual communications, conducted between individual members as part of the "vouching/back-up" Orientation relationship.

Grievance

- Grievance procedures are delineated in the Orientation procedure, which states "Any dispute or concern regarding a prospective worker during this process may be discussed privately amongst established Clinic staff, with a subsequent opportunity offered for review/appeal, that the prospective worker can attend to make their case. The consensus of established Clinic practitioners and staff, who provide direct patient care, and which is made primarily to facilitate patient care, is final.
- Additionally, the Orientation procedure states that among established group members, "Oppressive behavior will not be tolerated. This includes differential treatment on the basis of age, ethnicity, race, physical ability, physical appearance, gender, sexual orientation, and so on. However, it is understood that workers and patients from widely varying backgrounds may have varying sensitivities and interpretations. Therefore:
 - Behavior should be checked (request clarification) before being called out (verbally identified and interrupted).
 - Calling out of oppressive behavior will be respected. A person verbalizing a complaint of oppressive behavior will not be ignored, ostracized, mocked, or otherwise silenced.
 - The person who is called out should request clarification as to the behavior that is being questioned, to initiate resolution.
 - Disputes regarding oppressive behavior, which can't be resolved by simple discussion, will be privately mediated by a neutral third party acting as a fair witness. This may include but is not limited to the formal mediation process established by Occupy Eugene.
 - If a dispute is taken to a larger group for mediation, the fair witness must attend and testify.

Operations

- The center of operations is the Occupy Medical clinic, which is a set of services rather than a physical place. Occupy Medical clinical services may be provided on the Occupy Medical bus, in the Occupy Medical tent or pavilion, or elsewhere, on an as-needed basis (e.g., providing street support with portable medical care kits).

Patient Flow

1. Intake ("station 1"), in which identifying information is collected, patients may be "wait-listed" until seen by Triage, and previous records, if available, are prepared to facilitate continuous care. Intake physically passes the patient's chart to Triage. HIPAA privacy procedures may be explained to the patient, and written acknowledgment obtained, at any point in the patient flow, but typically these are managed by Intake.
2. Triage ("station 2"), in which vital signs and basic history of present illness are taken. The Triage worker may direct patients to Medical, Nursing, Wound Care, Dental, Counseling, Treatment, or other appropriate services. Triage passes the patient's chart to Direct Care.
3. Medical, Dental, Nursing, Wound Care, Counseling, or other Direct Care provider ("station 3"), as appropriate. The Direct Care provider documents the patient's present, past, family, and social history, an appropriate examination/evaluation, the provider's assessment of the key problem/s, and a mutually agreed-upon treatment plan. The Direct Care provider passes the patient's chart to Treatment.
4. Treatment ("station 4"), in which patients consult a pharmacist, herbalist, nutritionist, social worker, or other treatment facilitator, to concretely formulate the care plan. In some cases, a Treatment facilitator provides contact information for obtaining medication vouchers from local agencies. Other workers may provide supplements, remedies, dressings, and written instructions, to facilitate self-care. Still others may provide instructions for obtaining labwork, imaging, or specialty consultation.

Records

- HIPAA privacy rules:
 - are explained to every patient verbally, with written rules offered and acknowledgment documented,
 - are posted throughout the clinic,
 - are included in Orientation procedures,
 - and are followed explicitly.
- Patients do not transport their own charts, but charts are passed between clinic staff directly.
- Patient records are securely stored in a locked file outside of the clinic.
- Patient data compiled for quality improvement purposes is "de-identified" as specified by the HIPAA privacy law.

Safety and Hygiene

External safety:

- Security and mediation: One security chief is designated for each clinic, not to act as a "bouncer," but to facilitate conflict resolution, recruit help and delegate emergency authority, and liaise with law enforcement and the press as necessary.
- Fire safety: Working fire extinguishers are installed in the bus and clinic personnel are instructed in their use as part of orientation. Burning materials are not allowed on the bus or in the tent, or anywhere in direct patient care areas.
- Equipment: The security chief oversees operation of equipment, e.g. an external generator for clinic bus "shore power."
- Facilities management: The security chief maintains contact with road crew and engineering personnel to manage bus and tent set-up, take-down, and interim operations as needed.

Internal safety:

- Clear exits are maintained in all clinic settings, including bus and tent.
- "Welcome mat" rugs at entrances and exits allow dry floors to be maintained in direct-care areas.
- The tent setting is well ventilated by definition. The bus is furnished with working windows providing ventilation as needed.

Hygiene:

- Each "station" worker is responsible for wiping down patient contact surfaces with antibacterial solutions at the start of each work shift. *Example: Triage worker wipes down seats, counters, handles and rails with "bleach-wipes" at the start of their work shift. Then, two hours later, the next Triage worker repeats the procedure before beginning their shift.*
- Floors (on the bus) are swept at the start of each shift.
- Top-to-bottom cleaning (washing ceilings, windows, surfaces, floors, and cupboards, bins, and shelves) will be conducted twice yearly, and more frequently as needed in case of major exposures.
- For cleanup and disposal of body fluids (blood, abscess fluid, urine, vomit, etc.), see Addendum for Biohazard Protocol.
- Triage, Direct Care, and Treatment workers will clean their hands with hand sanitizer containing at least 60% alcohol, before and after direct patient contact, and frequently during procedures as needed.
- Triage, Direct Care, and Treatment workers will wear non-latex gloves as appropriate during direct patient contact and procedures, and continuously if open cuts or sores are present on the hands or fingernails.
- Triage, Direct Care, and Treatment workers will wear protective masks throughout their clinic shift, if they have an acute infectious disease, like the common cold. They are strongly encouraged to obtain a replacement and stay home when they are ill, to protect our vulnerable patients from communicable diseases.
- Protect against sharps injuries with due caution (e.g., do not re-cap hypodermic needles or hold suture needles with the fingers). Disposable sharps (hypodermic and suture needles; glass ampules, dropper bottles, and vacutainer tubes; scalpel blades and lancets; skin staples, disposable scissors, etc.) will be stored in a sealed red "sharps" container. When full, these will be given to medical offices for secure disposal. See Addendum for Needlestick Protocol.
- Observe Universal Precautions to prevent contagion. These are posted throughout the clinic and are part of the Orientation procedure. See Addendum for Universal Precautions Protocol.
- All personnel are encouraged to be fully vaccinated against Hepatitis B (HBV, a three-shot series) and Influenza (a yearly shot).

Addendum: Universal Precautions

These are posted through out the clinic and are part of the Orientation procedure.

Treat all body fluids as though they could be infectious:

1. Clean hands with hand sanitizer (containing at least 60% alcohol) before and after direct patient care.
2. Wear non-latex gloves if cuts, abrasions, sores, or other skin disruptions are present on caregiver hands or wrists.
3. Wear gloves when performing procedures involving contact with body fluids.
4. Wear a mask when performing examinations and treatments involving possible airborne droplets to or from the caregiver.
5. Wear goggles and/or a gown when performing procedures that may cause spillage of body fluids onto clothing.
6. Wear gloves (and gown as needed) when cleaning spills of body fluids of less than 250 mL (1 cup).
7. Wear gloves, mask, goggles, and gown/apron when cleaning spills of body fluids of 250 mL (1 cup) or more.
8. Dispose of protective gear in red biohazard bag if exposed to body fluids of more than 15 mL (1 tsp).

Addendum: Biohazard Protocol

Some body fluids or body products are NOT considered infectious for blood-borne diseases, unless they contain blood. These include mucus, spit, sweat, tears, urine, feces, pus, and vomit. However, they still may transmit other infectious diseases, such as gastrointestinal or pulmonic bacteria or viruses. For this reason, we observe universal precautions when handling even "lower risk" body fluids.

Biohazard cleanup equipment is stored in a bucket-kit containing:

- Small bottle household bleach (6% sodium hypochlorite)
- 1 gallon of water (if running water is unavailable)
- Box of latex gloves, large
- Pair of long dishwashing gloves, large
- Pair of goggles
- Roll of paper towels
- Salad tongs
- Small one-piece plastic dustpan
- Red biohazard bags (tear- and impact-resistant)
- Optional: rubber apron, to protect clothing from bleach solution

Body fluid cleanup:

1. Block entry to the area and alert nearby personnel.
2. Put on protective gear: gloves, goggles, gowning as appropriate.
3. Remove any sharps to a sealed sharps container.
4. Cover the fluid with paper toweling to minimize aerosolization during cleanup.
5. Mix 10% bleach solution: 9 parts water to 1 part bleach
6. Starting from the edges of the paper toweling, saturate the area in bleach solution; allow the solution to soak for 20 minutes
7. Gather up the toweling, using salad tongs if risk of broken glass or other sharps.
8. Dispose of toweling in red biohazard bag. Ventilate the area.
9. Wipe down entire area with more toweling and bleach solution, disposing in red biohazard bag. Allow to air dry with adequate ventilation.
10. Dispose of gloves and/or gown in red biohazard bag. Deliver biohazard bag to medical office for proper biohazard disposition.

Addendum: Needlestick/Exposure Protocol

Needlestick and similar exposures to blood borne diseases (HIV and hepatitis B and C) require quick action! A "Needlestick Protocol" Kit, containing written instructions, will be posted at each direct patient care station. The enclosed instructions are as follows:

Needlestick Protocol: WHAT TO DO

If you are exposed to a needle stick, splash in the eye, or other high-risk exposure:

1. Immediately dispose of sharps safely, if necessary.

2. Explain to the patient that you will now transfer their care to another clinic worker, while you care for your injury, and ask them to wait for this transfer.
3. Notify your replacement clinic worker that you are activating the Needlestick Protocol:
 - Both you and the patient will be tested for communicable diseases (i.e., receive free HIV and hepatitis testing through the HIV Alliance/Needle Exchange). This is NOT optional.
 - The clinic worker must obtain and document the patient's communicable-disease-risk status (remote and recent injection or needle use of any kind; blood transfusions, with year; known disease history).
 - Before the patient leaves the clinic, their correct contact information must be documented, for follow-up of this testing.
 - Before the patient leaves the clinic, they must be provided with written contact information for the HIV Alliance/Needle Exchange, and instructed to visit them for free testing:
HIV Alliance/Needle Exchange phone, 541-342-5088. Location, 1966 Garden Avenue, Eugene.
(Needle Exchange has mobile sites throughout the week - call for details.)
Alternatively, the patient may visit their personal physician; document this physician's contact information before the patient leaves the clinic, for followup.
 - Notify the patient that IF official documentation of recent negative HIV and hepatitis B/C testing is provided by medical authorities, no new testing or treatment are necessary.
4. Cleanse the wound thoroughly with alcohol-based hand sanitizer (containing at least 60% alcohol, which kills HIV, HBV, and HCV), or rinse eye/s very thoroughly with fresh water or sterile saline solution.
 - Do not squeeze a puncture wound - it causes microtrauma and swelling, and doesn't help.
5. Document the date, time, route of exposure, and patient and staff risk factors for blood-borne diseases. Deliver this information to the clinic manager.
 - The clinic manager is to open a file to document:
 1. The staff member's exposure report
 2. Patient's and staffer's test results (rapid HIV, HBsAg, anti-HBs antibodies, anti-HCV)
 3. Patient's and staffer's treatment plans (post-exposure prophylaxis/PEP and followup care, including emotional support and education)
 - Do NOT leave the clinic yourself, without a prescription for post-exposure prophylaxis (PEP, preventive medication) that you can fill and take within 2 hours of exposure, OR SOONER. See below for possible regimens.
 - Do NOT leave the clinic yourself, without documenting the injury/exposure, notifying the clinic manager, and planning your testing and treatment regimen.
6. Immediate testing:

The patient:

 - The patient should be rapid-tested for HIV (results within an hour), with a positive result followed by a Western blot for confirmation. Negative rapid tests do NOT require further testing.
 - The patient should be tested for viral hepatitis (HBV surface antigen, HBsAg, and anti-HCV antibodies) immediately.

The staffer:

 - If the patient's rapid HIV is negative, the staffer does NOT need HIV testing, other than routinely, or treatment (PEP).
 - If the patient is HIV positive, the exposed staffer should be tested for HIV immediately and at 6 and 12 weeks, and 6 months after exposure. Most people seroconvert in the first 3 months, if at all.
 - The staffer should be tested for hepatitis on the basis of the patient's results. See below for details.
7. HIV post-exposure prophylactic (PEP) treatment:
 - If the patient's HIV status is unknown, take immediate post-exposure prophylaxis medication (PEP) while waiting for the patient's rapid HIV test results.
 - If the patient is thought to be very low risk, you can wait 1-2 hours before starting PEP medication while awaiting rapid HIV testing. If no results within 2 hours, start PEP immediately. (You can stop the PEP if the patient later turns out to be HIV negative.)
 - If the patient is known to be HIV positive, start PEP immediately, and plan to continue it for 4 weeks. HIV-PEP is most effective if started within 1-2 hours of exposure, or sooner.

8. What drugs for HIV-PEP?

Call the National Clinicians' Postexposure Prophylaxis Hotline (PEpline) at 888-448-4911 for recommendations.

Possible regimens:

- Preferred: Truvada (tenofovir/emtricitabine, 300/200 mg once daily) plus Isentress (raltegravir, 400 mg twice daily).
- Alternative: Truvada (tenofovir/emtricitabine, 300/200 mg once daily) plus Reyataz (atazanavir, 300 mg once daily) and Norvir (ritonavir, 100 mg once daily),
OR Truvada (tenofovir/emtricitabine, 300/200 mg once daily) plus Prezista (darunavir, 800 mg once daily) and Norvir (ritonavir, 100 mg once daily) with food.
- Additional possible regimens: Atripla (efavirenz/tenofovir/emtricitabine, 600/300/200 mg once daily),
OR Truvada (tenofovir/emtricitabine, 300/200 mg once daily) plus Kaletra (lopinavir/ritonavir, 400/100 mg twice daily),
OR Zerit (stavudine, 30 mg twice daily) and Epivir (lamivudine, 150 mg twice daily) in place of tenfovir/emtricitabine in the above regimens if the latter is contraindicated.
- For pregnant workers: Combivir (zidovudine-lamivudine, 150/300 twice daily) and Kaletra (lopinavir/ritonavir, 400/100 mg twice daily). Efavirenz should not be used in women who are or might be pregnant.
- Drugs that should NOT be used are abacavir (Ziagen) and nevirapine (Viramune), which may cause severe and sometimes life-threatening side effects, especially during the first few weeks of exposure.

(Reference: <http://www.aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-treatment-guidelines/0/> Updated 3/28/2012.)

Plan to take HIV-PEP medication for 4 weeks or longer. If the patient is found to be HIV-negative, you can stop the PEP medication.

9. Hepatitis B testing and treatment:

- If the patient is HBV negative, you might not need further testing.
- If you have been vaccinated against hepatitis B, get tested to verify that you are immune.
If immune, you will have positive anti-HBs (antibodies to hepatitis B surface antigen, which is used to make the vaccine). You might not need further testing.
If you are not immune, and the patient is positive, (had a poor response, or the vaccine wore off), you will need to be treated as though unvaccinated.
- HBV-PEP consists of HBIG ("Hepagam," hepatitis B immunoglobulin, 0.06mg/kg, repeated in one month if not HBV immune) and/or hepatitis B vaccination (a 3-shot series).

10. Hepatitis C testing and treatment:

- If the patient is HCV negative, you don't need further testing for HCV, although the CDC recommends that adults born in 1945-1965, those who got blood before 1992, and many others with "mild" risk factors, get screened routinely for anti-HCV antibodies.
- If the patient is HCV positive, get follow-up testing for HCV RNA by PCR 4-6 weeks after exposure. Continue follow-up testing for anti-HCV antibodies by ELISA, HCV RNA, and liver enzymes (ALT and AST) 4-6 months after exposure.
- There is currently no PEP or vaccine for hepatitis C. Immunoglobulin (HCIG) and antiviral agents are NOT recommended. Consult your personal physician or a liver specialist for advice.

For latest CDC data, see <http://www.cdc.gov/hai/>

