Facility Site and Medical Record Review Preparation Checklist

Please read this information and use the attached preparation checklist as it will assist you to have a successful Medi-Cal and/or Cal-Medi-Connect on-site review. You may use this checklist now and in the future as part of your own internal monitoring.

IMPORTANT:

If this is not your initial review, there may be some changes to the State regulations since your last audit. Please feel free to contact your Nurse Reviewer PRIOR to your audit to clarify any of these criteria. Notifying your Nurse Reviewer is especially important if you have been audited by different health plans, programs, or reviewers in the past.

☑ This on-site facility review is a requirement and is necessary to participate as a Medi-Cal and/or Cal-Medi-Connect PCP.

☑ The enclosed Policies and Procedures list should currently be in your office and may be used as staff training if your MD has signed off that he/she approves

(See signature box at the top of page 1 of each policy. If your MD prefers to adopt all of the enclosed Policy and Procedures, please have him/her ***sign the signature page attached on page 8****).*

☑ The following is a summary of the main categories that your nurse auditor will be reviewing during your on-site review.

Please have everything ready before your scheduled review.
Thank you for your participation.

Administrative Criteria Mark off what you have as it applies to your practice. If an item does not apply, simply mark N/A.					
Corresponding Criteria	Criteria	Yes	No	N/A	Comment
	Current licenses for physicians and all licensed staff				
	Delegation of Services Agreement and Standard Procedures for PA's, NP's, CNM's				
	Medical Assistant's (MA) Diplomas, certification, or letter of training/competency				
	DEA registration for MD, PA, CNM, NP				
	X-ray technician certificate, if your office has a radiology unit				
	Medical waste management hauler contract and pick up logs				
	Current calibration/inspection stickers for medical equipment				
	CLIA certificate or waiver: *unless all that is performed in your office is venipuncture and blood withdrawal. All specimens must be sent out of the office for processing.*				
	Patient health education materials and resource information are available. *See Health Education Policy for additional resources if your office does not currently have any materials for use*				
	Health care personnel wear ID badges/tags printed with first name and title				
	Office uses Health Plan interpreter services for non/limited English proficient patients. These services are 24 hours access numbers. *See Chapter 17 in Policy and Procedure manual.*				
	Current CA Radiologic Health Branch Inspection Report and copy of Title 17. (O*nly if your office has a radiology unit*.)				

Employee Training Records *Policies & Procedures and forms are attached for you to use to meet staff education criteria. Documentation of staff training needs to be available for review at the time of audit. It should consist of agenda/class outline/Policy and Procedure, or class materials/training information, and sign-in sheet with the date of training. Staff training needs to be done upon hire, and annually, as noted in the categories below. Evidence of Staff Training is required for all staff, including Providers (MDs, RNs, PAs, NPs). If providers conduct educational training on materials, their names must be documented as the instructor on all training forms for staff.*				
Corresponding Criteria	Criteria	Yes	No	Comment
	Infection control/universal precautions **(*annual*)** **Provide evidence for the past 3 years for Periodic Survey.**			
	Blood borne pathogens exposure prevention with a copy of a site-specific blood borne pathogen exposure plan **(*annual*)** **Provide evidence for the past 3 years for Periodic Survey.**			
	Biohazardous waste handling **(*annual*)** **Provide evidence for the past 3 years for Periodic Survey.**			
	Fire prevention/safety			
	Emergency non-medical procedures (site evacuation, workplace violence)			
	Emergency medical procedures			

	Child abuse/elder abuse/domestic violence reporting			
	Patient confidentiality			
	Informed consent, including human sterilization (if applicable)			
	System for timely prior authorization requests/health plan referral process			
	Grievance/complaint procedure			
	Sensitive services/minors' rights (if applicable)			

Pharmaceutical/Clinical Services *If this is a periodic (triennial review) please provide logs for the past 3 years*				
Corresponding Criteria	Criteria	Yes	No	Comment
	Logs for checking expired drugs/test supplies			
	Internal medications and external medications are stored separately.			
	Drugs and medication supplies are stored (locked) and labeled properly			
	Only lawfully authorized persons dispense drugs to patients.			
	Controlled drug log (if applicable)			
	Needles and sharps are properly stored (locked)			
	Needlestick safety precautions are practiced on site; to include "safety engineered" needles			
	Refrigerator and freezer temperature logs are recorded daily *(only if medications, including vaccines are kept in refrigerator and freezer).* ***Dorm type refrigerators/freezers*** *are not acceptable. The refrigerator and freezer must be separate units-two door refrigerator/freezer or totally separate units.*			
	Drugs are stored separately from food, test reagents, germicides, disinfectants			
	Only qualified/trained personnel retrieve, prepare, or administer medications. (Remember MAs must verify the medication dose (with the MD, NP, RN, PA) prior to administering the medication.)			

Infection Control *If this is a periodic (triennial review) please provide logs for the past 3 years*				
Corresponding Criteria	Criteria	Yes	No	Comment
	If your office has an autoclave: **A. Monthly spore testing log of autoclave/steam sterilizer with documented results.** **B. Autoclave – office adheres to manufacturer/product label directions.**			
	EPA approved disinfectant solutions effective in killing HIV/HBV/TB			
	Personal Protective Equipment available to staff and readily kept together for protection against bloodborne pathogen hazards (water repelling gloves,			

	water repelling gown, goggles and face shield, mask.			
	If you perform cold sterilization the solution must be prepared according to the manufacturers label. Each container must be labeled with product name and expiration date.			
	Medical waste separate from regular trash and in red biohazard bag			
	Medical waste kept in rigid, leak-proof container with lid, labeled "Biohazard", in a secure area.			

Emergency Plan				
Corresponding Criteria	Criteria	Yes	No	Comment
	Ambu bags (infant, pediatric and adult as applicable to practice), oral airways (infant, pediatric and adult sizes – 40mm-110mm), oxygen tank (at least ¾ full) with appropriate sized masks or cannula tubing			
	Epinephrine and Benadryl, TB safety syringes, alcohol wipes and gloves in emergency kit			
	Medication dosage chart for each medication stored in emergency kit			
	At least one type of fire protection – fire extinguisher (with current tag)/smoke detector/fire alarm/sprinklers			
	Evacuation route maps posted in prominent place in patient treatment areas (with directions drawn for patients to take closest exit)			
	Emergency numbers are posted (local police, local fire, poison control, supervisors, providers) prominently with a documented annual update date			

Medical Records

A sampling of medical records will be reviewed to evaluate for compliance with CMS and DHCS documentation standards. The following are core elements that will be reviewed. Note: Be sure to focus on Preventive Care as this area may need special attention.

Corresponding Criteria	Criteria	Yes	No	Comment
	Chronic problems/significant conditions are listed in medical record.			
	Current continuous medications are listed, with name, strength, route, dosage, and frequency.			
	Allergies are prominently noted in the record.			
	If consultation is requested, there is a note from the consultant in the record. Consultation, laboratory, imaging reports filed in the chart are initialed and dated by the ordering provider to signify review.			
	Primary language and need for interpreter services is documented in chart.			
	Presence of advance health care directive or evidence information was offered (members 18 and over).			
	Emergency contact is identified.			
	Instruction for follow-up care is documented; i.e., return in 2 wks or return PRN.			
	Errors are lined out with a single line, "error" written with initials and date.			
	Updated Vaccine Information Sheets (VIS) are available in threshold languages www.cdc.gov/vaccines/pubs/vis			

Preventative Care - Pediatrics				
Corresponding Criteria	Criteria	Yes	No	Comment
	Initial Health Assessment (IHA) is completed on all new members within 120 days of enrollment (use eligibility list from IPA). If no evidence in medical record then reason must be documented (member's refusal, missed appointment, etc. or if no patient file document on eligibility list/log). See enclosed IHA letters to send to new members.			
	Individual Health Education Behavioral Assessment (IHEBA) ("Staying Healthy" assessment) form is filled out and in the medical record for new members within 120 days of enrollment. IHEBA is re-administered at 0-6Mo; 7-12Mo; 1-2yrs; 3-4yrs; 5-8yrs; 9-11 yrs; 12-17 yrs, ADULT & SENIOR. Interventions, dates, and physician signature are documented directly on the form. Provider Office Training is required for the NEW updated forms.			
	Age appropriate physical exams are done according to AAP guidelines and include CHDP components.			
	Dental assessment/referral to dentist beginning at age 3 regardless whether problem is detected.			
	Vision screening (at each health assessment visit and referral to optometrist/ophthalmologist as needed).			
	Hearing screening (non-audiometric for age 2 months to 3 years; audiometric screening for age 3-21 yrs at each health assessment visit). *Scores must be documented.*			
	Nutritional assessment screening. Includes referral to WIC for members under age 5.			
	Lead testing age 12 months and 24 months or up to 72 months if not done at 12 and 24 months.			
	Tuberculosis risk screening at each health assessment visit. *See copies of risk assessment questionnaire that may be implemented*. Tab 32			
	Immunization status is assessed at each health assessment visit. VIS (Vaccine Information Sheets) are given. Document date given and VIS publication date.			

Preventative Care - Adults				
Corresponding Criteria	Criteria	Yes	No	Comment
	Initial Health Assessment (IHA) is completed on all new members within 120 days of enrollment (use eligibility list) OR documented within the past 12 months prior to member's enrollment. If the IHA is not present in the medical record, member's refusal, missed appointments or other reason must be documented.			
	Individual Health Education Behavioral Assessment (IHEBA) ("Staying Healthy" assessment) [SHA] form is filled out and in the medical record for new members within 120 days of enrollment. For adults age 18 or older; ADULT and SENIOR SHA reviewed annually and is re-administered every 3-5 years or more frequently. Interventions, dates, and physician signature are documented directly on the form. *See chapter 21 of Policy and Procedure manual.*			
	Periodic health evaluation (See enclosed health screening and immunization guide). *See chapter 18 of Policy and Procedure manual.*			
	Tuberculosis risk screening at each health assessment visit. TAB 32			
	Blood pressure			
	Lipid Panel			

	Chlamydia screening – annual screening of all sexually active females age 25 and younger			
	Mammogram/pap smear status			
	Adult immunization status – including Tetanus, flu vaccine, pneumococcal vaccine – if given at PCP office, Vaccine Information Statement (VIS) date given and VIS publication date must be documented.			

Preventative Care - Perinatal				
Corresponding Criteria	Criteria	Yes	No	Comment
	Initial comprehensive prenatal assessment (ICA) is completed within 4 weeks of entry into prenatal care			
	Subsequent comprehensive prenatal trimester reassessments			
	Individualized care plan (ICP) documentation is found in the medical record			
	Referral to WIC and assessment of Infant Feeding status. All potentially eligible members must be referred to WIC and documented in the medical record. Infant feeding plans are documented during prenatal period, and infant feeding status is documented during postpartum period			
	HIV-related services offered			
	AFP/genetic screening offered			
	Family planning counseling/referral/provision of services is documented in the medical record			
	Postpartum assessments			

Simple, functional, written policies that are followed in the office need to be in place. Below is a comprehensive list of policies (if applicable to your practice) that should be in place at the time of audit. Examples of each policy are attached in this packet. If a provider decides to use these specific policies, please check off which (or all) policies and have him/her sign below (page 8) to acknowledge use of all attached policies as they are written. Any revisions to a policy can be made and encouraged in order to reflect your office practice. Simply indicate which policies were revised and present the revised policy to the nurse reviewer at the time of the audit. When a revision is made, ensure that the approving provider signs the top right-hand corner of the policy to indicate the implementation of this policy and procedure in the practice. If no revisions are made, continue with signing on page 8, indicating no policies have been revised (or writing "none"). Periodic review of these policies and procedures should be in place. Best practice would be to review (and document such review) at a minimum of each year.

	Policy Description	Check if applicable
➢	Site accessibility by individuals with physical disabilities	
➢	Clean and sanitary environment	
➢	Fire safety and prevention and emergency non-medical procedures	
➢	Medical and lab equipment maintenance	
➢	Emergency health care services	
➢	Staff qualifications – health care license and certification requirements	
➢	Non-physician medical practitioners	
➢	Unlicensed personnel	
➢	Personnel training	
➢	Prior authorization/referrals	
➢	Informed consent	
➢	Minor's rights	
➢	Member grievances/complaints	
➢	Interpreter services	
➢	Medical records	
➢	Provision of services 24 hours a day	
➢	Appointments and patient recall	
➢	Referral and consultative services	
➢	Individual health education behavioral assessment ("Staying Healthy" Assessment Tool) (IHEBA)	
➢	Triage	
➢	Laboratory services	
➢	Pharmaceutical services	
➢	Radiology services	
➢	Health education	
➢	Preventive services: screening and equipment	
➢	Bloodborne pathogens and waste management	
➢	Decontamination of surfaces	
➢	Standard and universal precautions	
➢	Instrument sterilization	
➢	Miscellaneous Forms	

POLICY AND PROCEDURE MANUAL

PROVIDER ACKNOWLEDGEMENT SIGNATURE PAGE

By signing below, I agree that the above checked policies and procedures have been adopted and implemented in my practice. I agree to revise and maintain copies of revisions as policies and procedures in my practice change. When changes are made, I will ensure proper staff training of such changes are shared with staff and documented via a staff in-service training sign in sheet conducted by myself or a designated site personnel such as an office manager or clinic supervisor.

Date	Name of Reviewing Physician(s)	Signature	Review Date	P&P Number(s) Revised – if none, indicate “none”

PRE-AUDIT PREPARATION

FACILITY SITE REVIEW TIPS

Nine (9) Critical Elements (These criteria are worth 2 points each)

1. Exit doors & aisles are unobstructed and egress (escape) accessible

- Accessible pedestrian paths of travel provide a clear circulation path.
- Escape routes are maintained free of obstructions or impediments to full instant use of the path of travel in case of fire or other emergency.
- Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied.
- Cords or other items are not placed on or across walkway areas.

2. Airway Management

- Must have a wall oxygen delivery system or portable oxygen tank that is maintained at least ¾ full. Portable oxygen tank must have a flow meter attached. MA must be able to demonstrate proper way of turning oxygen tank on/off.
- There is a method/system in place for oxygen tank replacement.
- There are various sizes of oral oropharyngeal airways devices appropriate to patient population available on site. If seeing infants, must have ALL sizes:
    - 40 mm Infant
    - 50 mm Newborn
    - 60 mm Toddler
    - 70 mm Child
    - 80 mm Teen
    - 90 mm Adult
    - 100 mm Large Adult
    - 110 mm Extra Large Adult
- There is a nasal cannula or mask available and various sizes of ambu bags appropriate to patient population available on site.

3. Qualified personnel prepare/administer medication

- There must be a licensed physician physically present in the treatment facility during the performance of authorized procedures by the Medical Assistant (MA).
- There must be a process in place and verbalized by the MA(s), at the time of survey, that the pre-labeled medication container and prepared dose are shown to the licensed person prior to administration.
- The supervising physician must specifically authorize all medications administered by an MA.

4. Timely review & follow-up of referral/consultation reports & test results

- Site staff can demonstrate the office referral process from beginning to end.
- Referral process must include physician review.
- A process for follow-up of referral/consultation reports and diagnostic test results is in place.

5. Authorized persons dispense medications

- Drug dispensing is in compliance with all applicable State and Federal laws and regulations.
- Drugs are dispensed only by a physician, pharmacist or other persons lawfully authorized to dispense medications upon the order of a licensed physician or surgeon.

6. Personal protective equipment

- PPE is available for staff use on-site & includes water repelling gloves, water-resistant gowns, face/eye protection (e.g. face shield or goggles), & respiratory infection protection (mask).
- PPE “kit” kept together in a bag; readily available

7. Needle stick precautions are practiced on site

- Engineered Sharps Injury Protection (ESIP) devices are used on site
- Contaminated sharps are discarded immediately.
- Sharps containers are: 1) located close to the immediate area where sharps are used; 2) inaccessible to unauthorized persons; 3) secured (locked) in patient care areas at all times; and 4) not overfilled past manufacturer’s designated fill line or more than ¾ full.

8. Blood and other infectious materials storage and handling

- Containers for blood and other potentially infectious materials (OPIM) are closable, leak proof, and labeled and/or color-coded.
- Double bagging is required only if leakage is possible.

9. Spore testing of autoclave/steam sterilizer

- Autoclave spore testing is performed at least monthly.
- Written procedures for performing routine spore testing and for handling positive spore test results are available on site to staff.
- For positive spore tests, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs.
- Procedures include: report problem, repair autoclave, retrieve all instruments sterilized since last negative spore test, re-test autoclave and re-sterilize retrieved instruments.

- **Evidence of Staff Safety Training (Including MD, PA, NP, CNM) must be available on-site and must be retained on-site for at least 3 years**. The training agenda and office policies signed and approved by MD must also be available on-site. Required topics include:
    - **1**. Infection Control/Universal Precautions (ANNUALLY)
    - **2**. Bloodborne Pathogens (ANNUALLY)
    - **3**. Biohazardous Waste Handling (ANNUALLY)
    - **4**. Child/Elder/Domestic Violence Abuse
    - **5**. Patient Confidentiality
    - **6**. Informed Consent, including Human Sterilization
    - **7**. Prior Authorization requests
    - **8**. Grievance/Complaint Procedure
    - **9**. Sensitive Services/Minors Rights
    - **10**. Health Plan referral process/procedures
    - **11**. Fire Safety and Prevention
    - **12**. Non-Medical Emergency (e.g. site evacuation, workplace violence)
    - **13**. Medical Emergency
- **A complete "Site-Specific" Bloodborne Pathogen Exposure Control Plan is required for each site.**
    - Each address/site must have a separate plan. (Sample is enclosed)
- **Required Emergency Equipment:**
    - O2 tank with a flow meter and a regulator/gauge which indicates the amount of oxygen. Must be STORED TOGETHER with emergency equipment. Both must be easily accessible only to staff.
    - Ambu bags, oral airways, and mask/nasal cannula with tubing in appropriate sizes
    - Epinephrine 1:1000 IM and Benadryl 50mg IM (or Benadryl 25 mg PO)
    - Appropriate sizes of syringes and safety needles
    - Alcohol wipes
    - A medication dosage chart shall be kept with the emergency medication. If you have other medications in your E-Kit, dosages for emergency indications of each medication should be included. (Package inserts are not acceptable as dosage charts)
    - Evidence of monthly checks/logs of delivery system of O2, maintenance of emergency equipment, and expirations of emergency medications must be kept for **3 years**.
- **"Notice to Consumers" signage for all physicians and physician assistants must be visible to members as it is required by the Medical Board of California.**
- **Agreements and supervision between Supervising physician and Mid-level Practitioner guidelines are revised, updated, and signed annually.**
    - Documentation of supervision of MA by Mid-levels when MD is not on-site must be included for clinics regulated under H&S code 1204.
- **Staff should be able to demonstrate or explain isolation procedures including airborne precaution.**
- **A routine decontamination of work surface shall be available in writing on site.**
    - A written cleaning log shall be followed for regular routine cleaning. Logs must be kept for 3 years. Staff shall be able to identify the frequency for routine cleaning of surfaces and equipment, the disinfectant used, and responsible personnel.
    - Environmental Protection Agency (EPA) Approved disinfectant must be used according to manufacturer's instructions and must be effective in killing HIV, HepB, and TB.
- **Reconstituted 10% Bleach is only effective for 24 hours and has a 5 minute contact/kill time for maximum efficacy.**
    - If using Bleach:
        - Must have at least 6.15% Sodium Hypochlorite
        - Original bottle must be present at time of audit
        - 10% Bleach is 1 part Bleach to 9 parts water
- **All generic bottles containing hazardous substances (Alcohol, Bleach, etc.) must be labeled with:**
    - Name of solution
    - Date of mixing
    - Hazardous warning label

- **MA must have proof of certifications applicable to job description:**
    - 10 hr completion of venipuncture and skin puncture training for the purpose of withdrawing blood
    - 10 hr completion of administering injections and performing skin tests training
        - MA diploma is not sufficient proof unless specifically states 10 hr completion
- **Open multi-dose medication and vaccine vials must be dated with open date and must be within 28 days of opening or will be considered expired** (unless manufacturer specifies otherwise)
- **Sites generating less than 20 lbs of biohazardous waste per month shall not contain or store waste above 0 degrees Centigrade or 32 degrees Fahrenheit at any on-site location for more than 30 days.**
    - If a site generates 20lbs or more biohazardous waste per month, the site shall not contain or store biohazardous waste or sharps waste at any on-site location for more than **7 days** without obtaining prior written approval of the enforcement agency.
- **CA Senate Bill 1966, Chapter 536 is a law that regulates the handling, management, and disposal of pharmaceutical waste in California.** The law is regulated by DHCS and the Medical Waste Management Act to help eliminate pharmaceutical waste from solid waste and public sewer systems. This includes all expired medications and lab tubes (with additives).
    - Store expired medications in the Medical Waste Container (blue and white container, not red)
    - Check with your pharmaceutical reps, local pharmacy, and lab vendors if they are willing to dispose of these substances.
- **Confidentiality of Protected Health Information, member's grievances, referral processes, authorization for specialist, and release of records are required**. Staff should be able to explain all these procedures.
- **Staff should know members' rights and minors' rights**.
- **Process in place to assess site personnel, used as interpreters, for their medical interpretation performance skills/capabilities.**
- **Staff must know how to assist limited English-proficient members.** Staff must know how to access translation services that are available to members
    - Staff must be competent to translate
    - Process in place to assess translating staff on their medical interpretation skills
        - Staff must be assessed for their medical interpretation performance
- **Health Education materials for members are reviewed and approved by DHCS** for readability, cultural/linguistic appropriateness and accuracy. M also be available for members at all times and in threshold languages.
- **Per Cal-OSHA, the usage of safety needles/syringes and sharps are required to reduce injuries and exposure to bloodborne pathogens.** As of July 1, 2002, DHCS required all clinic offices to use only these safety needles/syringes for injections and blood withdrawal. A sharps injury log must be kept and maintained at all sites to document "sharps" injuries when they occur. **Sharps containers must be secured, wall mounted, or locked at all times**.
- **Site Staff can demonstrate the office referral process from beginning to end.** Referral tracking system and/or log must be in place to monitor all aspects of the members' referral to a specialist.
    - Approval authorization, appointment completion, and receipt of consult reports
    - Receipt of all consult reports shall be tracked/logged, forwarded to provider for review, and signed then filed in the member's medical record

*Please refer to most current DHCS Site Review Survey Tool and Guidelines

MEDICAL RECORD REVIEW TIPS

- **All medical record entries are signed, dated and legible**.
    - Signatures, at minimum, must include first initial, full last name, and title of health care personnel providing care, including Medical Assistants. (e.g. vital signs, hearing, vision, etc.)
    - Initials may only be used if signatures are specifically identified elsewhere in the medical record (e.g. signature page)
- **Advance Health Care Directive information is offered to members 18 years of age or older or to emancipated minors**.
    - Document date advance directive information offered if no advance directive on file.
    - POLST is acceptable only if signed/dated by both doctor and patient
- **Missed appointments and follow-up contacts/outreach efforts are documented in the medical record.**
- **An Initial Health Assessment (IHA) and an age-appropriate Individual Health Education Behavioral Assessment (IHEBA or Staying Healthy Assessment (SHA)) or other DHCS-approved tool is completed within 120 days of PCP effective date or within the 12 months prior**.
    - If no IHA or IHEBA/SHA within 120 days or within last 12 months, documentation of outreach efforts must be documented.
    - The IHEBA/SHA has evidence of **practitioner review such as name, signature and date**.
    - **Interventions** must be noted when high risk behaviors are identified.
    - An age-appropriate IHEBA/SHA is re-administered when the member has reached the next specific age interval designated by MMCD following the same documentation requirements.
- **Tuberculosis (TB) risk factors are assessed for all children and adults upon enrollment and at each periodic physical evaluation**. The Mantoux skin test, or other approved TB infection screening test, is administered to high risk children and adults if there has not been a test in the previous year.
- **Adult Immunization status is assessed at every periodic health evaluation: flu, Td/Tdap, and (if indicated) pneumovax**.
    - Documentation must include:
        - Name of vaccine, manufacturer, lot number
        - Vaccine information Statement (VIS) publication date
        - Date Vaccine information Statement (VIS) given to patient

***Please refer to most current DHCS Medical Record Review Tool and Guidelines**

Full Scope

Site Review Survey 2012

Attachment A

California Department of Health Care Services

Health Plan_____ **IPA** _____**Site ID No.**_____ **Review Date:** _____ **Last review:** _____

Provider/Address _____ **Phone** _____ **Fax** _____ **Fire Clearance**_____

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Current Yes/No

_____ **Contact person/title**_____

No. of staff on site _____ **Physician** _____ **NP** _____**CNM** _____ **PA** **Reviewer/title** _____

_____ **RN** _____ **LVN** _____ **MA** _____ **Clerical** _____ **other** **Reviewer/title**_____

Visit Purpose	Site-Specific Certification(s)	Provider Type	Clinic Type
_____ Initial Full Scope _____ Monitoring	_____ AAAHC _____ JCAHO	_____ Family Practice _____ Internal Medicine	_____ Primary Care _____ Community
_____ Periodic Full Scope _____ Follow-up	_____ CHDP _____ NCQA	_____ Pediatrics _____ OB/GYN	_____ Hospital _____ FQHC
_____ Focused Review _____ Ed/TA	_____ CPSP _____ None	_____ General Practice _____ Specialist	_____ Rural Health _____ Other _____ (type)
_____Other _____ (type)	_____ Other _____	_____ Mid level (type) _____	_____ Solo _____ Group _____ Staff/Teaching

Site Scores

	Points Poss.	Yes Pts. Given	No's	N/A's	CE's
I. Access/Safety	**(29)**				
II. Personnel	**(22)**				
III. Office Management	**(25)**				
IV. Clinical Services	**(34)**				
V. Preventive Services	**(13)**				
VI. Infection Control	**(27)**				
	(150)				
	Total Pts. Poss.	**Yes Pts. Given**	**No's**	**N/A's**	**CE's**

Scoring Procedure

1) Add points given in each section.
2) Add total points given for all six sections.
3) Adjust score for "N/A" criteria (if needed), by subtracting N/A points from 150 total points poss.
4) Divide total points given by 150 or by "adjusted" total points.
5) Multiply by 100 to get the compliance (percent) rate.

_____ ÷ _____ = _____ X 100 = _____%

Points Given / **Total / Adjusted Points** / **Decimal Score** / **Compliance Rate**

Note: CE's column may be used for easy reference to see if there are Critical Elements that trigger a CAP.

Compliance Rate

_____ **Exempted Pass: 90% or above** (*without* deficiencies in Critical Elements, Pharmaceutical Services or Infection Control)

_____ **Conditional Pass: 80-89%, or 90% and above** *with* deficiencies in Critical Elements, Pharmaceutical Services or Infection Control

_____ **Not Pass: Below 80%**

_____ CAP Required

_____ Other follow-up

Next Review Due: _____

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Site Review Guidelines 2012

California Department of Health Care Services
Medi-Cal Managed Care Division

Purpose: Site Review Guidelines provide the standards, directions, instructions, rules, regulations, perimeters, or indicators for the site review survey. These Guidelines shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions.

Scoring: Site survey includes on-site inspection and interviews with site personnel. Reviewers are expected to use reasonable evidence available during the review process to determine if practices and systems on site meet survey criteria. Compliance levels include:

1) Exempted Pass: 90% or above *without deficiencies* in Critical Elements, Pharmaceutical or Infection Control
2) Conditional Pass: 80-89%, or 90% and above with deficiencies in either Critical Elements, Pharmaceutical or Infection Control
3) Not Pass: below 80%

A corrective action plan (CAP) is required for a total score less than 90%, *OR* for a total score of 90% or above if there are deficiencies in Critical Elements, Pharmaceutical Services or Infection Control. Compliance rates are based on 150 total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Reviewers are expected to determine how to ascertain information needed to complete the survey. Survey criteria to be reviewed only by a R.N. or physician is labeled **RN/MD Review only**

Directions: Score full point(s) if survey item is met. Score zero (0) points if item is not met. Do not score partial points for any item. Explain all "N/A" and "No" (0 point) items in the comment section. Provide assistance/consultation as needed for CAPs, and establish follow-up/verification timeline.

1) Add the points given in each section.
2) Add points given for all six (6) sections to determine total points given for the site.
3) Subtract all "N/A" items from 150 total possible points to determine the "adjusted" total possible points. If there are no "N/A" items, calculation of site score will be based on 150 points.
4) Divide the total points given by 150 or by the "adjusted" total. Multiply by 100 to calculate percentage rate.

Scoring Example:

Step 1: Add the points given in each section.	**Step 2**: Add points given for all six (6) sections. Example: 25 (Access/safety) 22 (Personnel) 23 (Office Management) 34 (Clinical Services) 11 (Preventive Services) 25 (Infection Control) **140 (POINTS)**
Step 3: Subtract "N/A" points from 150 total points possible. 150 (Total points possible) – 5 (N/A points) 145 ("Adjusted" total points possible)	**Step 4**: Divide total points given by 150 or by the "adjusted" points, then multiply by 100 to calculate percentage rate. Points given / 150 or "adjusted" total or 140 / 145 = 0.97 X 100 = **97%**

Criteria	I. Access/Safety Reviewer Guidelines
A. Site is accessible and useable by individuals with physical disabilities.	• **ADA Regulations**: Site must meet city, county and state building structure and access ordinances for persons with physical disabilities. A site/facility includes the building structure, walkways, parking lots, and equipment. All facilities designed, constructed; or altered by, on behalf of, or for the use of a public entity must be readily accessible and usable by individuals with disabilities, if the construction or alteration was begun after January 26, 1992 (28 CFR 35.151). Any alteration to a place of public accommodation or a commercial facility, after January 26, 1992, must be made to ensure that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and useable by individuals with disabilities, including individuals who use wheelchairs (28 CFR 36.402). • **Parking**: Parking spaces for persons with physical disabilities are located in close proximity to handicap-accessible building entrances. Each parking space reserved for the disabled is identified by a permanently affixed reflectorized sign posted in a conspicuous place. If provider has no control over availability of disabled parking lot or nearby street spaces, provider must have a plan in place for making program services available to persons with physical disabilities. • **Ramps**: A clear and level landing is at the top and bottom of all ramps and on each side of an exit door. Any path of travel is considered a ramp if its slope is greater than a 1-foot rise in 20 feet of horizontal run. • **Exit doors**: The width of exit doorways (at least 32-in. or reasonable accommodation) allows for passage clearance of a wheelchair. Exit doors include all doors required for access, circulation and use of the building and facilities, such as primary entrances and passageway doors. Furniture and other items do not obstruct exit doorways or interfere with door swing pathway. • **Elevators**: If there is no passenger elevator, a freight elevator may be used to achieve program accessibility if it is upgraded for general passenger use and if passageways leading to and from the elevator are well-lit, neat and clean. • **Clear Floor Space**: Clear space in waiting/exam areas is sufficient (at least 30-in. x 48-in.) to accommodate a single, stationary adult wheelchair and occupant. A minimum clear space of 60-in. diameter or square area is needed to turn a wheelchair. • **Sanitary Facilities**: Restroom and hand washing facilities are accessible to able-bodied and physically disabled persons. A wheel-chair accessible restroom stall allows sufficient space for a wheelchair to enter and permits the door to close. If wheelchair accessible restrooms are not available within the office site, reasonable alternative accommodations are provided. Alternatives may include: grab bars located behind and/or along the sides of toilet with assistance provided as needed by site personnel; provision of urinal, bedpan, or bedside commode placed in a private area; wheelchair accessible restroom located in a nearby office or shared within a building. Sufficient knee clearance space underneath the sink allows for wheelchair users to safely use a lavatory sink for hand washing. A reasonable alternative may include, but is not limited to, hand washing items provided as needed by site personnel. **Note:** A public entity may not deny the benefits of its program, activities, and services to individuals with disabilities because its facilities are inaccessible (28 CFR 35.149-35.150). Every feature need not be accessible, if a reasonable portion of the facilities and accommodations provided is accessible (Title 24, Section 2-419, California Administrative Code, the State Building Code). Reasonable Portion and/or Reasonable Alternatives are acceptable to achieve program accessibility. Reasonable Portion applies to multi-storied structures and provides exceptions to the regulations requiring accessibility to all portions of a facility/site. Reasonable Alternatives are methods other than site structural changes to achieve program accessibility, such as acquisition or redesign of equipment, assignment of assistants/aides to beneficiaries, provision of services at alternate accessible sites, and/or other site specific alternatives to provide services (ADA, Title II, 5.2000). Points shall not be deducted if Reasonable Portion or Reasonable Alternative is made available on site. **Specific measurements are provided strictly for "*reference only*" for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.**

I. Access/Safety (continued on next page)

Site Access/Safety Survey Criteria	Yes	No	N/A	Wt.	Site Score
A. Site is accessible and useable by individuals with physical disabilities. 24 CCR (CA Building Standards Code); 28 CFR §35 (American Disabilities Act of 1990, Title II, Title III) Sites must have the following safety accommodations for physically disabled persons:					
1) Clearly marked (blue) curb or sign designating disabled-parking space near accessible primary entrance.	**1)** ____	**1)**_____	**1)**_____	**1**	
2) Pedestrian ramps have a level landing at the top and bottom of the ramp.	**2)**_____	**2)**_____	**2)**_____	**1**	
3) Exit doorway openings allow for clear passage of a person in a wheelchair.	**3)**_____	**3)**_____	**3)**_____	**1**	
4) Accessible passenger elevator or reasonable alternative for multi-level floor accommodation.	**4)**_____	**4)**_____	**4)**_____	**1**	
5) Clear floor space for wheelchair in waiting area and exam room.	**5)**_____	**5)**_____	**5)**_____	**1**	
6) Wheelchair accessible restroom facilities or reasonable alternative.	**6)**_____	**6)**_____	**6)**_____	**1**	
7) Wheelchair accessible hand washing facilities or reasonable alternative.	**7)**_____	**7)**_____	**7)**_____	**1**	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

Criteria	I. Access/Safety Reviewer Guidelines
B. Site environment is maintained in a clean and sanitary condition.	The physical appearance of floors/carpets, walls, furniture, patient areas and restrooms are clean and well maintained. Appropriate sanitary supplies, such as toilet tissue, hand washing soap, cloth/paper towels or antiseptic towelettes are made available for restroom use. Environmental safety includes the "housekeeping" or hygienic condition of the site. Clean means unsoiled, neat, tidy, and uncluttered. Well maintained means being in good repair or condition.
C. Site environment is safe for all patients, visitors and personnel.	• **Ordinances**: Sites must meet city, county and state fire safety and prevention ordinances. Reviewers should be aware of applicable city and county ordinances in the areas in which they conduct reviews. • **Non-medical emergency procedures:** Non-medical emergencies include incidents of fire, natural disaster (e.g. earthquakes), workplace violence, etc. Specific information for handling fire emergencies and evacuation procedures is available on site to staff. Personnel know ***where to locate*** information on site, and ***how to use*** information. Evidence of training must be verifiable, and may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • **Evacuation Routes**: Clearly marked, easy-to-follow escape routes are posted in visible areas, such as hallways, exam rooms and patient waiting areas. The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route, but may be reduced to a minimum of 32 inches at a doorway. • **Illumination**: Lighting is adequate in patient flow working and walking areas such as corridors, walkways, waiting and exam rooms, and restrooms to allow for a safe path of travel. • **Access Aisle**: Accessible pedestrian paths of travel (ramps, corridors, walkways, lobbies, elevators, etc.) between elements (seats, tables, displays, equipment, parking spaces, etc.) provide a clear circulation path. Means of egress (escape routes) are maintained free of obstructions or impediments to full instant use of the path of travel in case of fire or other emergency. Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied. Cords (including taped cords) or other items are not placed on or across walkway areas. • **Exits**: Exit doorways are unobstructed and clearly marked by a readily visible "Exit" sign. • **Electrical Safety**: Electrical cords are in good working condition with no exposed wires, or frayed or cracked areas. Cords are not affixed to structures, placed in or across walkways, extended through walls, floors, and ceiling or under doors or floor coverings. Extension cords are not used as a substitute for permanent wiring. All electrical outlets have an intact wall faceplate. Sufficient clearance is maintained around lights and heating units to prevent combustible ignition. • **Fire Fighting/Protection Equipment**: There is fire fighting/protection equipment in an accessible location on site at all times. An accessible location is reachable by personnel standing on the floor, or other permanent working area, without the need to locate/retrieve step stool, ladder or other assistive devices. At least one of the following types of fire safety equipment is on site: 1) Smoke Detector with intact, working batteries. 2) Fire Alarm Device with code and reporting instructions posted conspicuously at phones and employee entrances. 3) Automatic Sprinkler System with sufficient clearance (10-in.) between sprinkler heads and stored materials. 4) Fire Extinguisher in an accessible location that displays readiness indicators or has an attached current dated inspection tag. **Note: Specific measurements are provided strictly for "*reference only*" for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.**

I. Access/Safety (continued on next page)

Site Access/Safety Survey Criteria	Yes	No	N/A	Wt.	Site Score
B. Site environment is maintained in a clean and sanitary condition. 8 CCR §5193; 28 CCR §1300.80					
1) All patient areas including floor/carpet, walls, and furniture are neat, clean and well maintained.	**1)**_____	**1)**_____	**1)**_____	**1**	
2) Restrooms are clean and contain appropriate sanitary supplies.	**2)**_____	**2)**_____	**2)**_____	**1**	
C. Site environment is safe for all patients, visitors and personnel. 8 CCR §3220; 22 CCR §53230; 24 CCR, §2, §3, §9; 28 CCR §1300.80; 29 CFR §1910.301, §1926.34					
There is evidence that staff has received safety training and/or has safety information available in the following: 1) Fire safety and prevention	**1)**_____	**1)**_____	**1)**_____	**1**	
2) Emergency non-medical procedures (e.g. site evacuation, workplace violence)	**2)**_____	**2)**_____	**2)**_____	**1**	
The following fire and safety precautions are evidenced on site: 3) Lighting is adequate in all areas to ensure safety.	**3)**_____	**3)**_____	**3)**_____	**1**	
4) **Exit doors and aisles are unobstructed and egress (escape) accessible**.	**4)**_____	**4)**_____	**4)**_____	**2**	
5) Exit doors are clearly marked with "Exit" signs.	**5)**_____	**5)**_____	**5)**_____	**1**	
6) Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location.	**6)**_____	**6)**_____	**6)**_____	**1**	
7) Electrical cords and outlets are in good working condition.	**7)**_____	**7)**_____	**7)**_____	**1**	
8) At least one type of fire fighting/protection equipment is accessible at all times.	**8)**_____	**8)**_____	**8)**_____	**1**	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only

Criteria	I. Access/Safety Reviewer Guidelines
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week.	• **Site Specific Emergency procedures**: Staff is able to describe site-specific actions or procedures for handling medical emergencies until the individual is stable or under care of local emergency medical services (EMS). There is a written procedure for providing immediate emergent medical care on site until the local EMS is on the scene. Although site proximity to emergency care facilities may be considered when evaluating medical emergency procedures, the key factor is the ability to provide immediate care to patients *on site* until the patient is stable or EMS has taken over care/treatment. When the MD or NPMP is not onsite, staff/MA may call 911, and CPR-certified staff may initiate CPR if needed. Non-CPR-certified staff may only call 911 and stay with the patient until help arrives. • **Emergency medical equipment**: During business hours providers are prepared to provide emergency services for management of emergency medical conditions that occur on site ***until*** the emergent situation is stabilized and/or treatment is initiated by the local 911 Emergency Medical Service (EMS) system. Minimum emergency equipment is available on site to: 1) establish and maintain a patent/open airway, and 2) manage anaphylactic reaction. Emergency equipment and medication, appropriate to patient population, are available in an accessible location. An accessible location is one that is reachable by personnel standing on the floor, or other permanent working area, without locating/retrieving step stool, ladder or other assistive devices. For emergency "Crash" cart/kit, contents are appropriately sealed and are within the expiration dates posted on label/seal. Site personnel are appropriately trained and can demonstrate knowledge and correct use of all medical equipment they are expected to operate within their scope of work. Documented evidence that emergency equipment is checked at least monthly may include a log, checklist or other appropriate method(s). • **Emergency phone number list**: Posted list includes local emergency response services (e.g., fire, police/sheriff, ambulance), emergency contacts (e.g., responsible managers, supervisors), and appropriate State, County, City and local agencies (e.g., local poison control number). The list should be dated, and updated annually. • **Airway management**: Without the ability to adequately maintain the patient's airway, all other interventions are futile. Minimum airway control equipment includes a wall oxygen delivery system or portable oxygen tank, oropharyngeal airways, nasal cannula or mask, and Ambu Bag. Various sizes of airway devices appropriate to patient population within the practice are on site. Portable oxygen tanks are maintained at least ¾ full. There is a method/system in place for oxygen tank replacement. If oxygen tanks are less than ¾ full at time of site visit, site has a back-up method for supplying oxygen if needed ***and*** a scheduled plan for tank replacement. Oxygen tubing need not be connected to oxygen tank, but must be kept in close proximity to tank. Health care personnel at the site must demonstrate that they can turn on the oxygen tank**.** • **Anaphylactic reaction management**: Severe allergic reaction can cause urticaria (hives), hypotension, bronchospasm, wheezing and pulmonary edema. Minimum equipment includes Epinephrine 1:1000 (injectable), and Benadryl 25 mg. (oral) or Benadryl 50 mg/ml (injectable), appropriate sizes of ESIP needles/syringes*and alcohol wipes. (*If the emergency kit or "crash cart" has only non-safety needles/syringes, score that deficiency in Section VI., Infection Control, criteria B.2. See Infection Control guidelines). There is a current medication administration reference (e.g. medication dosage chart) available for readily identifying the correct medication dosages (e.g. adult, pediatric, infant, etc.). Package inserts are not acceptable as dosage charts. **Note:** An "emergency medical condition" is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: 1) placing the health of the individual (or unborn child of a pregnant woman) in serious jeopardy, 2) serious impairment to bodily functions, and 3) serious dysfunction of any bodily organ or part. "Emergency services" means those services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death.

I. Access/Safety (continued on next page)

RN/MD Review only

Site Access/Safety Survey Criteria	Yes	No	N/A	Wt.	Site Score
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week. 22 CCR §51056, §53216; 28 CCR §1300.67					
1) Personnel are trained in procedures/action plan to be carried out in case of medical emergency on site.	**1)____**	**1)____**	**1)____**	**1**	
2) Emergency equipment is stored together in easily accessible location.	**2)____**	**2)____**	**2)____**	**1**	
3) Emergency phone number contacts are posted.	**3)____**	**3)____**	**3)____**	**1**	
Emergency medical equipment appropriate to practice/patient population is available on site: 4) **Airway management: oxygen delivery system, oral airways, nasal cannula or mask, Ambu bag.**	**4)____**	**4)____**	**4)____**	**2**	
5) Anaphylactic reaction management: Epinephrine 1:1000 (injectable), and Benadryl 25 mg. (oral) or Benadryl 50 mg./ml. (injectable), appropriate sizes of ESIP needles/syringes and alcohol wipes.	**5)____**	**5)____**	**5)____**	**1**	
6) Medication dosage chart (or other method for determining dosage) is kept with emergency medications.	**6)____**	**6)____**	**6)____**	**1**	
There is a process in place on site to: 7) Document checking of emergency equipment/supplies for expiration and operating status at least monthly.	**7)____**	**7)____**	**7)____**	**1**	
8) Replace/re-stock emergency equipment immediately after use.	**8)____**	**8)____**	**8)____**	**1**	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only

Criteria	I. Access/Safety Reviewer Guidelines
E. Medical and lab equipment used for patient care is properly maintained.	• **Medical and laboratory equipment**: All equipment used to measure or assess patient health status/condition is clean. • **Documentation**: There is documented evidence that standard operating procedures have been followed for routine inspection/ maintenance, calibration, repair of failure or malfunction, and testing and cleaning of all specialized equipment. Appropriate written records include calibration or other written logs, work orders, service receipts, dated inspection sticker, etc. All equipment used to measure or assess patient health status/condition is functioning properly. All specialized equipment (e.g., ultrasonography equipment, electrocardiogram (EKG) machine, defibrillator, audiometer, hemoglobin meter, glucometer, scales, etc.) are adequately maintained according to the specified manufacturer's guidelines for the equipment, or is serviced annually by a qualified technician. Blood pressure cuffs, monitors, and other related equipment need not be calibrated unless required by the manufacturer. Manufacturer guidelines must be available on site, indicating that it is not necessary to calibrate the equipment. Note: The term monitor includes, but not limited to, glucometers, EKG, BP monitors, hemacues, and audiometers.

I. Access/Safety (continued from previous page)

RN/MD Review only

Site Access/Safety Survey Criteria	Yes	No	N/A	Wt.	Site Score
E Medical and lab equipment used for patient care is properly maintained. CA Health & Safety Code §111255; 28 CCR §1300.80; 21 CFR §800-1299					
1) Medical equipment is clean.	**1)_____**	**1)_____**	**1)_____**	**1**	
2) Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines.	**2)_____**	**2)_____**	**2)_____**	**1**	
Comments: Write comments for all "No" (0 points) and "N/A" scores.					
TOTALS					

<table>
<tr><th>Criteria</th><th colspan="3">II. Personnel Reviewer Guidelines</th></tr>
<tr><td rowspan="14">A. Professional health care personnel have current California licenses and certifications.</td><th>Medical Professional</th><th>License/Certification</th><th>Issuing Agency</th></tr>
<tr><td>Certified Nurse Midwife (CNM)</td><td>RN License & Nurse-Midwife Certificate.
DEA Registration, if appropriate</td><td>CA Board of Registered Nursing
Drug Enforcement Administration (DEA)</td></tr>
<tr><td>Certified Radiological Technologist (CRT)</td><td>CRT Certificate.</td><td>CDPH, Radiologic Health Branch</td></tr>
<tr><td>Doctor of Osteopathy (DO)</td><td>Physician’s & Surgeon’s Certificate.
DEA Registration</td><td>Osteopathic Medical Board of CA
DEA</td></tr>
<tr><td>Licensed Vocational Nurse (LVN):</td><td>LVN License.</td><td>CA Board of Vocational Nursing and Psychiatric Technicians</td></tr>
<tr><td>Nurse Practitioner (NP)</td><td>RN License w/NP Certification & Furnishing Number. DEA Registration, if appropriate</td><td>CA Board of Registered Nursing
DEA</td></tr>
<tr><td>Pharmacist (Pharm. D)</td><td>Pharmacist License</td><td>CA State Board of Pharmacy</td></tr>
<tr><td>Physician/Surgeon (MD)</td><td>Physician’s & Surgeon’s Certificate.
DEA Registration</td><td>Medical Board of CA
DEA</td></tr>
<tr><td>Physicians’ Assistant (PA)</td><td>PA License.
DEA Registration, if appropriate</td><td>Physician Assistant Examining Committee/Medical Board of CA, DEA</td></tr>
<tr><td>Radiological Technician</td><td>Limited Permit.</td><td>CDPH, Radiologic Health Branch</td></tr>
<tr><td>Registered Dietitian (RD)</td><td>RD Registration Card.</td><td>Commission on Dietetic Registration</td></tr>
<tr><td>Registered Nurse (RN)</td><td>RN License.</td><td>CA Board of Registered Nursing</td></tr>
<tr><td colspan="3"><u>Note:</u> All medical professional licenses and certifications must be current and issued from the appropriate agency for practice in California, and available on site. Although sites with centralized personnel departments are not required to keep documents or copies on site, copies and/or lists of currently certified or credentialed personnel must be readily available when requested by reviewers.</td></tr>
<tr><td colspan="3"><table>
<tr><td><u>Note:</u> Effective June 27, 2010, per CCR, Title 16, 1355.4, mandated by Business and Professions Code section 138, MDs (does not apply to Osteopaths) shall provide notification to each patient that states the MD(s) on site is licensed and regulated by the Board, and includes the following:

NOTICE
Medical doctors are licensed and regulated
by the Medical Board of California
(800) 633-2322
<u>www.mbc.ca.gov</u>.</td><td><u>Note:</u> Effective August 11, 2011, per CCR, Title 16, 1399.547, mandated by Business and Professions Code section 138, PAs shall provide notification to each patient that states the PA(s) is licensed and regulated by the Physician Assistant Committee, and includes the following:

NOTIFICATION TO CONSUMERS
Physician Assistants are licensed and regulated
by the Physician Assistant Committee
(916) 561-8780
<u>www.pac.ca.gov</u></td></tr>
</table>
The notice to consumers above shall be provided by one of the following methods: 1) prominently posted sign in an area visible to patients in at least 48-pt Arial font, 2) a written statement signed and dated by the patient (or patient’s representative) and kept in the medical record, stating the patient understands that the MD is licensed and licensed and regulated by the board (for PA’s, that the PA is licensed and regulated by the PA Committee), or 3) a statement on letterhead, discharge instructions or other document given to the patient (or patient’s representative), where the notification is placed immediately above the signature line for the patient in a at least 14-pt font.</td></tr>
<tr><td>B. Health care personnel are properly identified.</td><td colspan="3">Health care personnel shall disclose, while working, their name and title on a name tag at least 18-point type. It is acceptable for health care personnel in a practice or an office, whose license is prominently displayed, to opt not to wear a nametag. In the interest of public safety and consumer awareness, it shall be unlawful for any person to use the title “nurse” in reference to himself or herself, in any capacity, except for an individual who is a registered nurse, or a licensed vocational nurse. <u>Note:</u> “Health care practitioner” means any person who engages in acts that are the subject of licensure or regulation under the CA B&P Code (Section 680-681). If a health care practitioner or licensed clinical social worker is working in a psychiatric setting or in a setting that is not licensed by the state, the employing entity or agency shall have the discretion to make an exception from the name tag requirement for the individual safety or therapeutic concerns.</td></tr>
</table>

II. Personnel (continued on next page)

Site Personnel Survey Criteria	Yes	No	N/A	Wt.	Site Score
A. Professional health care personnel have current California licenses and certifications. CA Business & Professional (B&P) Code §2050, §2085**,** §2725, §2746, §2834, §3500, §4110; CCR, Title 16, §1355.4, §1399.547 1) All required Professional Licenses and Certifications, issued from the appropriate licensing/certification agency, are current. Notification is provided to each member that the MD(s) is licensed and regulated by the Medical Board, and that the Physician Assistant(s) is licensed and regulated by the Physician Assistant Committee.	**1)_____**	**1)_____**	**1)_____**	**1**	
B. Health care personnel are properly identified. CA B&P Code §680, AB 1439 1) Health care personnel wear identification badges/tags printed with name and title.	**1)_____**	**1)_____**	**1)_____**	**1**	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only

Criteria	II. Personnel Reviewer Guidelines
C. Site personnel are qualified and trained for assigned responsibilities.	• **Medical equipment:** Provider and/or staff are able to demonstrate appropriate operation of medical equipment used in their scope of work. Not all staff is required to be proficient in use of all equipment. • **Unlicensed personnel**: Medical assistants (MA) are unlicensed health personnel, at least 18 years of age, who perform basic administrative, clerical, and non-invasive routine technical supportive services under the supervision of a licensed physician, surgeon or podiatrist in a medical office or clinic setting. Supervision means the licensed physician must be physically present in the treatment facility during the performance of authorized procedures by the MA. Training may be administered under a licensed physician; or under a RN, LVN, PA, or other qualified medical assistant acting under the direction of a licensed physician. The supervising physician is responsible for determining the training content and ascertaining proficiency of the MA. Training documentation maintained on site for the MA must include the following: A) Diploma or certification from an accredited training program/school, ***or*** B) Letter/statement from the current supervising physician that certifies in writing: date, location, content, and duration of training, demonstrated proficiency to perform current assigned scope of work, and signature. • **Medications**: Unlicensed staff (e.g. medical assistants) has evidence of appropriate training and supervision in all medication administration methods performed within their scope of work. Medication administration by a MA means the direct application of pre-measured medication orally, sublingually, topically, vaginally or rectally; or by providing a single dose to a patient for immediate self-administration by inhalation or by simple injection. **All medications including vaccines must be verified with (shown to) a licensed person prior to administration.** To administer medications by subcutaneous or intramuscular injection, or to perform intradermal skin tests or venipunctures for withdrawing blood, an MA must have completed at least the minimum number of training-hours established in CCR, Title 16, Section 1366.1. **MAs cannot administer anesthetics, including local anesthetic agents (such as Rocephin hydrated with Xylocaine).** Medical assistants may not place an intravenous needle, start or disconnect the intravenous infusion tube, administer medications or injections into an intravenous line, or administer anesthesia. The supervising physician must specifically authorize all medications administered by an MA. Authorization means a specific written or standing order prepared by the supervising physician. **Note:** Personnel on site must be qualified for their responsibilities and adequately trained for their scope of work. Site staff should have a general understanding of the systems/processes in place, appropriate supervision and knowledge of the available sources of information on site.

II. Personnel (continued on next page)

RN/MD Review only

Site Personnel Survey Criteria	Yes	No	N/A	Wt.	Site Score
C. Site personnel are qualified and trained for assigned responsibilities. CA B&P Code §2069; 16 CCR §1366; 22 CCR §75034, §75035					
1) **Only qualified/trained personnel retrieve, prepare or administer medications.**	**1)_____**	**1)_____**	**1)_____**	**2**	
2) Only qualified/trained personnel operate medical equipment.	**2)_____**	**2)_____**	**2)_____**	**1**	
3) Documentation of education/training for non-licensed medical personnel is maintained on site.	**3)_____**	**3)_____**	**3)_____**	**1**	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only

Criteria	II. Personnel Reviewer Guidelines
D. Scope of practice for non-physician medical practitioners (NPMP) is clearly defined.	Reviewers are expected to verify that NP and/or CNM standardized procedures, and PA Delegation of Services Agreement and Supervision Physician's Responsibility documentation are present on site. Reviewers are ***not*** expected to make in-depth evaluation of "appropriateness" of the NPMP's scope of practice. Documents may be utilized to determine and/or clarify practice procedures and supervisory processes on site. • **Certified Nurse Midwives** (CNM): The certificate to practice nurse-midwifery authorizes the holder, under supervision of a licensed physician or surgeon, to attend cases of normal child-birth and to provide prenatal, intrapartum, and postpartum care, including family planning care for the mother, and immediate care for the newborn. The supervising and back-up physician or surgeon for the CNM must be credentialed to perform obstetrical care in the same delivering facility in which the CNM has delivery privileges. • **Nurse Practitioners** (NP): Nurse practitioners are prepared through education and experience to provide primary care and to perform advanced procedures. The extent of required supervision must be specified in the Standardized Procedures. • **Physician Assistants** (PA): Every PA is required to have the following documents: 1) Delegation of Services Agreement: Defines specific procedures identified in practice protocols or specifically authorized by the supervising physician, and must be dated and signed by physician and PA. An original or copy must be readily accessible at all practice sites in which the PA works. There is no established time period for renewing the Agreement, but it is expected that the Agreement will be revised, dated and signed whenever any changes occur. Failure to maintain a Delegation of Services Agreement is a violation of the Physician Assistant Regulations and is grounds for disciplinary action by the Medical Board of California against a physician assistant's licensure. 2) Approved Supervising Physician's Responsibility for Supervision of Physician Assistants Agreement: Defines supervision responsibilities and methods required by Title 16, section 1399.545 of the Physician Assistant Regulations, and is signed by the physician. The following procedures must be identified: a) Transport and back-up procedures for when the supervising physician is not on the premises. b) One or more methods for performing medical record review by the supervising physician: c) Responsibility for physician review and countersigning of medical records d) Responsibility of the PA to enter the name of approved supervising physician responsible for the patient on the medical record. • **Drug Enforcement Agency** (DEA): Each NP, CNM, and PA that prescribes controlled substances is required to have a valid DEA Registration Number. **Note:** Standardized procedures legally define the expanded scope of nursing practice that overlaps the practice of medicine. CNMs and NPs operate under written Standardized Procedures that are collaboratively developed and approved by the supervising physician, the NP and administration within the organized health care facility/system in which standardized procedures will be used. Standardized Procedures should identify the furnishing of drugs or devices, extent of physician or surgeon supervision, method of periodic review of competence, including peer review, and review of provisions in the Standardized Procedures. Standardized Procedures shall undergo periodic review, with signed, dated revisions completed at each change in scope of work.

II. Personnel (continued on next page)

RN/MD Review only

Site Personnel Survey Criteria	Yes	No	N/A	Wt.	Site Score
D. Scope of practice for non-physician medical practitioners (NPMP) is clearly defined. 16 CCR §1379, §1399.540, §1399.545, §1474, CA B&P Code §2725.1					
1) Standardized Procedures provided for Nurse Practitioners (NP) and/or Certified Nurse Midwives (CNM).	1)_____	1)_____	1)_____	1	
2) A Delegation of Services Agreement defines the scope of services provided by Physician Assistants (PA) and Supervisory Guidelines define the method of supervision by the Supervising Physician.	2)_____	2)_____	2)_____	1	
3) Standardized Procedures, Delegation of Services Agreements and Supervisory Guidelines are revised, updated and signed by the supervising physician and NPMP when changes in scope of services occur.	3)_____	3)_____	3)_____	1	
4) Each NPMP that prescribes controlled substances has a valid DEA Registration Number.	4)_____	4)_____	4)_____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only

Criteria	II. Personnel Reviewer Guidelines
E. Non-physician medical practitioners (NPMP) are supervised according to established standards.	• **Non-physician medical practitioners**: The Supervising Physician holds ultimate responsibility for the practice of each supervised non-physician medical practitioner. The number of non-physician medical practitioners who may be supervised by a single primary care physician is limited to the full-time equivalent of one of the following: 4 nurse practitioners, 3 nurse midwives, 4 physician's assistants, or 4 of the above individuals in any combination which does not exceed the limit stated. This ratio is based on each physician, not the number of offices. A primary care physician, an organized outpatient clinic or a hospital outpatient department cannot utilize more non-physician medical practitioners than can be supervised within these stated limits. Ref: Assembly Bill 3 Bass, Chapter 376, October 2007, effective January 1, 2008, allows 4 PAs to 1 MD; Business & Professions Code 3516(b); W & I Code 14132.966. Physician Assistant Committee is at: http://www.pac.ca.gov/ or the PAC office at 916-561-8780. • **Supervising physician**: "Supervising physician" means a physician and/or surgeon licensed by the Medical Board or by the Osteopathic Medical Board of California who supervises one or more physician assistants, possesses a current valid license to practice medicine, and is not currently on disciplinary probation for improper use of a physician assistant. "Supervision" means that a licensed physician and surgeon oversee the activities of, and accept responsibility for, the medical services rendered by a physician assistant. Physicians must comply with all current and/or revised requirements established by the Medical Board of CA for supervising physician assistants.

II. Personnel (continued on next page)

RN/MD Review only

Site Personnel Survey Criteria	Yes	No	N/A	Wt.	Site Score
E. Non-physician medical practitioners (NPMP) are supervised according to established standards. B&P Code 3516(b); W&I Code 14132.966					
The designated supervising physician(s) on site: 1) ratio to number of NPMPs does not exceed established ratios in any combination. a) 1:4 Nurse Practitioners b) 1:3 Certified Nurse Midwives c) 1:4 Physicians Assistants	1)_____	1)_____	1)_____	1	
2) The designated supervising or back-up physician is available in person or by electronic communication at all times when a NPMP is caring for patients.	2)_____	2)_____	2)_____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only

Criteria	II. Personnel Reviewer Guidelines
F. Site personnel receive safety training/information.	• **Bloodborne Pathogens**: Site personnel treat all blood and other potentially infectious materials (OPIM) as if these *are* infectious. Site personnel who are reasonably anticipated to have eye, skin, mucous membranes and potential exposure to blood and/or other potentially infectious materials (OPIM) receive training as required by the Bloodborne Pathogens Standard, Title 8, CCR, Section 5193. Training occurs ***prior to*** initial exposure to potentially infectious and/or biohazardous materials. Review and re-training sessions occur ***at least annually***. Training content is appropriate (language, educational level, etc.) to personnel on site. Training *minimally* includes the following: ‣ universal/standard precautions ‣ use of personal protective equipment ‣ accessible copy of Bloodborne Pathogens Standard ‣ work practice controls/exposure prevention ‣ modes of transmitting bloodborne pathogens ‣ epidemiology/symptoms of HBV and HIV ‣ recognition of activities with exposure element ‣ handling and labeling of biohazardous waste(s) ‣ Hepatitis B vaccination protocol and requirements ‣ explanation of emergency procedures ‣ post exposure reporting/evaluation/follow-up procedures ‣ decontamination of equipment/work areas ‣ site's written bloodborne pathogen exposure plan ‣ opportunity for discussion/questions Personnel must know ***where to locate*** information/resources on site about infection control, the Bloodborne Pathogens Exposure Plan, and ***how to use*** the information. Evidence of training must be verifiable. Evidence of training may include informal in-services, new staff orientation, external training courses, educational curriculum and participation lists, etc. Training documentation must contain the employee's name, job titles, training date(s), type of training, contents of training session, and names/qualifications of trainers. Records must be kept for three (3) years. • **Abuse Reporting**: Site personnel have specific knowledge of local reporting requirements, agencies, and procedures, and know *where to locat*e information on site and *how to use* information. **Note:** Health practitioners (e.g., physicians, surgeons, licensed nurses, licensed social workers, paramedics) in a health facility, (e.g., clinic, physician's office, public health clinic) are legally mandated reporters of known or reasonably suspected cases of child abuse, elder abuse and domestic violence. Legally mandated reporters must make telephone and written reports according to timeliness standards established by the designated local law enforcement agencies in each county. "Reasonably suspects" means having objectively reasonable suspicion based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect abuse (CA Penal Code 11164). Failure to report by legally mandated reporters can result in criminal or civil prosecutions, punishable by monetary fines and/or county jail confinement. Any person entering employment which makes him/her a mandated reporter must sign a statement, provided and retained by the employer, that the employee has knowledge of the Child Abuse reporting law and will comply with its provision (CA Penal Code 11166.5).

II. Personnel (continued on next page)

RN/MD Review only

Site Personnel Survey Criteria	Yes	No	N/A	Wt.	Site Score
F. Site personnel receive safety training/information. 8 CCR §5193; CA H&S Code §117600; CA Penal Code §11164, §11168; 29 CFR §1910.1030 There is evidence that site staff has received training and/or information on the following:					
1) Infection control/universal precautions (annually)	**1)____**	**1)____**	**1)____**	**1**	
2) Blood Borne Pathogens Exposure Prevention (annually)	**2)____**	**2)____**	**2)____**	**1**	
3) Biohazardous Waste handling (annually)	**3)____**	**3)____**	**3)____**	**1**	
4) Child/Elder/Domestic Violence Abuse	**4)____**	**4)____**	**4)____**	**1**	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only

Criteria	II. Personnel Reviewer Guidelines
G. Site personnel receive training and/or information on member rights.	Site personnel have received information and/or training about member rights. Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. If there is no verifiable evidence of staff training, staff is able to locate written member rights information on site and explain how to use information.

II. Personnel (continued from previous page)

RN/MD Review only

Site Personnel Survey Criteria	Yes	No	N/A	Wt.	Site Score
G. Site personnel receive training and/or information on member rights. 22 CCR §51009, §51014.1, §51305.1, §53452, §53858; 28 CCR §1300.68 There is evidence that site staff has received training and/or information on the following:					
1) Patient Confidentiality	**1)____**	**1)____**	**1)____**	**1**	
2) Informed consent, including Human Sterilization	**2)____**	**2)____**	**2)____**	**1**	
3) Prior Authorization requests	**3)____**	**3)____**	**3)____**	**1**	
4) Grievance/Complaint Procedure	**4)____**	**4)____**	**4)____**	**1**	
5) Sensitive Services/Minors' Rights	**5)____**	**5)____**	**5)____**	**1**	
6) Health Plan referral process/procedures/resources	**6)____**	**6)____**	**6)____**	**1**	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **Totals**					

RN/MD Review only (#B)

Criteria	III. Office Management Reviewer Guidelines
A. Physician coverage is available 24 hours a day, 7 days a week.	Current clinic office hours are posted within the office or readily available upon request. Current site-specific resource information is available to site personnel about physician office hour schedule(s), local and/or Plan-specific systems for after-hours urgent care, emergent physician coverage available 24 hours a day, 7 days per week, and system for providing follow-up care. When a physician is not on site during regular office hours, personnel are able to contact the physician (or covering physician) at all times by telephone, cell phone, pager, etc. **Note:** One objective of effective clinic office management is to support the provision of appropriate, coordinated health care services. The review of clinic office management is to evaluate if effective systems are in place and whether site personnel appropriately follow established site-specific procedures.
B. There is sufficient health care personnel to provide timely, appropriate health care services.	In addition to the physician, only appropriately licensed medical personnel such as a CNM, NP, RN, or PA handles emergency, urgent, and medical advice/triage telephone calls. The California Board of Vocational Nursing and Psychiatric Technician Examiners has determined that the Licensed Vocational Nurse Practice Act ***does not*** permit the LVN to perform triage independently (MCPB Letter 92-15). The LVN may perform that part of the triage process that includes observation and data collection relative to basic physical assessment. The LVN ***may not*** perform that part of the triage process that includes independent evaluation, interpretation of data, and determination of treatment priorities and levels of care. Unlicensed personnel, such as medical assistants, may provide patient information or instructions only as authorized by the physician (Title 16, §1366 (b)). **Note:** Telephone triage is the system for managing telephone callers during ***and*** after office hours.

III. Office Management (continued on next page)

RN/MD Review only (#B)

Office Management Survey Criteria	Yes	No	N/A	Wt.	Site Score
A. Physician coverage is available 24 hours a day, 7 days a week. 22 CCR §56500, §53855 The following are maintained current on site:					
1) Clinic office hours are posted, or readily available upon request.	1)_____	1)_____	1)_____	1	
2) Provider office hour schedules are available to staff.	2)_____	2)_____	2)_____	1	
3) Arrangement/schedule for after-hours, on-call, supervisory back-up physician coverage is available to site staff.	3)_____	3)_____	3)_____	1	
4) Contact information for off-site physician(s) is available at all times during office hours.	4)_____	4)_____	4)_____	1	
5) After-hours emergency care instructions/telephone information is made available to patients.	5)_____	5)_____	5)_____	1	
B. There is sufficient health care personnel to provide timely, appropriate health care services. 22 CCR §53855; 28 CCR §1300.67.1, §1300.80					
1) Appropriate personnel handle emergent, urgent, and medical advice telephone calls.	1)_____	1)_____	1)_____	1	
2) Telephone answering machine, voice mail system or answering service is used whenever office staff does not directly answer phone calls.	2)_____	2)_____	2)_____	1	
3) Telephone system, answering service, recorded telephone information, and recording device are periodically checked and updated.	3)_____	3)_____	3)_____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only (#C)

Criteria	III. Office Management Reviewer Guidelines
C. Health care services are readily available.	The process established on site provides timely access to appointments for routine care, urgent care, prenatal care, pediatric periodic health assessments/immunizations, adult initial health assessments, specialty care and emergency care. An organized system must be clearly evident (in use) for scheduling appointments appropriately, notifying and reminding members of scheduled appointments, and following up of missed or canceled appointments. Systems, practices and procedures used for making services readily available to patients will vary from site to site. Missed and/or canceled appointments, and contact attempts must be documented in the patient's medical record. **Note:** Medi-Cal Managed Care Health Plans *require* the following timeliness standards for access to appointments: • Urgent Care: 48 hours • Access to the first Prenatal Visit: 10 business days • Non-urgent (Routine) Care: 10 business days
D. There is 24-hour access to interpreter services for non- or limited-English proficient (LEP) members.	All sites must provide 24-hour interpreter services for all members either through telephone language services or interpreters on site. Site personnel used as interpreters have been assessed for their medical interpretation performance skills/capabilities. A family member or friend may be used as an interpreter if requested by the LEP individual after being informed of their right to use free interpreter services. **Note:** Assessment of interpreter skills may include written or oral assessment of bilingual skills, documentation of the number of years of employment as an interpreter or translator, documentation of successful completion of a specific type of interpreter training programs (medical, legal, court, semi-technical, etc.), and/or other reasonable alternative documentation of interpreter capability. A request for or refusal of language/ interpreter services must be documented in the member's medical record.

III. Office Management (continued on next page)

RN/MD Review only (#C)

Office Management Survey Criteria	Yes	No	N/A	Wt.	Site Score
C. Health care services are readily available. 22 CCR §56000(2)					
1) Appointments are scheduled according to patients' stated clinical needs within the timeliness standards established for Plan members.	1)_____	1)_____	1)_____	1	
2) Patients are notified of scheduled routine and/or preventive screening appointments.	2)_____	2)_____	2)_____	1	
3) There is a process in place verifying follow-up on missed and canceled appointments.	3)_____	3)_____	3)_____	1	
D. There is 24-hour access to interpreter services for non- or limited-English proficient (LEP) members. 22 CCR §53851; 28 CCR 1300.67.04					
1) Interpreter services are made available in identified threshold languages specified for location of site.	1)_____	1)_____	1)_____	1	
2) Persons providing language interpreter services on site are trained in medical interpretation.	2)_____	2)_____	2)_____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only (#E)

Criteria	III. Office Management Reviewer Guidelines
E. Procedures for timely referral/ consultative services are established on site.	An organized, timely referral system is clearly evident for making and tracking referrals, reviewing reports, providing/scheduling follow-up care and filing reports in medical records. Referral informational resources are readily available for use by site personnel. Site staff can demonstrate (e.g., "walk through") the office referral process from beginning to end. Systems, practices and procedures used for handling referrals will vary from site to site.
F. Member grievance/ complaint processes are established on site.	At least one telephone number for filing grievances is posted on site, or is readily available upon request. Complaint forms and a copy of the grievance procedure are readily available on site, and can be provided to members promptly upon request. **Note:** A "grievance" is defined as any written or oral expression of dissatisfaction and shall include any complaint, dispute, request for reconsideration or appeal made by an enrollee or their representative to a Plan or entity with delegated authority to resolve grievances on behalf of the Plan.

III. Office Management (continued on next page)

RN/MD Review only (#E)

Office Management Survey Criteria	Yes	No	N/A	Wt.	Site Score
E. Procedures for timely referral/consultative services are established on site. 22 CCR §53851; 28 CCR §1300.67 and §1300.80					
Office practice procedures allow timely provision and tracking of: 1) Processing internal and external referrals, consultant reports and diagnostic test results	1)_____	1)_____	1)_____	1	
2) **Physician review and follow-up of referral/consultation reports and diagnostic test results**.	2)_____	2)_____	2)_____	2	
F. Member Grievance/Complaint processes are established on site. 22 CCR §53858, §56260					
1) Phone number(s) for filing grievances/complaints are located on site.	1)_____	1)_____	1)_____	1	
2) Complaint forms and a copy of the grievance procedure(s) are available on site.	2)_____	2)_____	2)_____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only (#H)

Criteria	III. Office Management Reviewer Guidelines
G. Medical records are available for the practitioner at each scheduled patient encounter.	The process/system established on site provides for the availability of medical records (paper and electronic), including outpatient, inpatient, referral services, and significant telephone consultations for patient encounters. Medical records are filed that allows for ease of accessibility within the facility, or in an approved health record storage facility off the facility premises (22 CCR, § 75055).
H. Confidentiality of personal medical information is protected according to State and federal guidelines.	• **Privacy**: Patients have the right to privacy for dressing/undressing, physical examination and medical consultation. Practices are in place to safeguard patient privacy. Because dressing areas and examination room configurations vary greatly, reviewers will make site-specific determinations. • **Confidentiality**: Personnel follow site policy/procedures for maintaining confidentiality of individual patient information. Individual patient conditions or information is not discussed in front of other patients or visitors, displayed or left unattended in reception and/or patient flow areas. • **Electronic records**: Electronic record-keeping system procedures have been established to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain upkeep of computer systems. Security protection includes an off-site backup storage system, an image mechanism with the ability to copy documents, a mechanism to ensure that recorded input is unalterable, and file recovery procedures. Confidentiality protection may also include use of encryption, detailed user access controls, transaction logs, and blinded files. • **Record release**: Medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released. The release terms, such as to whom records are released and for what purposes, should also be described. This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities and State or local official agencies. • **Record retention:** Hospitals, acute psychiatric hospitals, skilled nursing facilities, *primary care clinics*, psychology and psychiatric clinics must maintain medical records and exposed x-rays for a minimum of 7 years following patient discharge, except for minors (Title 22, CCR, Section 75055). Records of minors must be maintained for at least one year after a minor has reached age 18, but in no event for less than **7** years (Title 22, CCR, Section 75055). Each Plan must maintain all records and documentation (including medical records) necessary to verify information and reports required by statute, regulation or contractual obligation for 5 years from the end of the fiscal year in which the Plan contract expires or is terminated (Title 22, CCR, Section 53861).

III. Office Management (continued from previous page)

RN/MD Review only (#H)

Office Management Survey Criteria	Yes	No	N/A	Wt.	Site Score
G. Medical records are available for the practitioner at each scheduled patient encounter. 22 CCR §75055; 28 CCR §1300.80					
1) Medical records are readily retrievable for scheduled patient encounters.	**1)____**	**1)____**	**1)____**	**1**	
2) Medical documents are filed in a timely manner to ensure availability for patient encounters.	**2)____**	**2)____**	**2)____**	**1**	
H. Confidentiality of personal medical information is protected according to State and federal guidelines. 22 CCR §51009, §53861, §75055; §28 CCR §1300.80; CA Civil Code §56.10 (Confidentiality of Medical Information Act)					
1) Exam rooms and dressing areas safeguard patients' right to privacy.	**1)____**	**1)____**	**1)____**	**1**	
2) Procedures are followed to maintain the confidentiality of personal patient information.	**2)____**	**2)____**	**2)____**	**1**	
3) Medical record release procedures are compliant with State and federal guidelines.	**3)____**	**3)____**	**3)____**	**1**	
4) Storage and transmittal of medical records preserves confidentiality and security.	**4)____**	**4)____**	**4)____**	**1**	
5) Medical records are retained for a minimum of 7 years according to 22 CCR Section 75055.	**5)____**	**5)____**	**5)____**	**1**	
Comments: Write comments for all "No" (0 points) and "N/A" scores.					
Totals					

Criteria	IV. Clinical Services - Pharmaceutical Reviewer Guidelines
A. Drugs and medication supplies are maintained secured to prevent unauthorized access.	• **Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan. • **Controlled substances**: Written records are maintained of controlled substances inventory list(s) that includes: provider's DEA number, name of medication, original quantity of drug, dose, date, name of patient receiving drug, name of authorized person dispensing drug, and number of remaining doses. Controlled substances are stored separately from other drugs in a securely locked, substantially constructed cabinet (Control Substances Act, CFR 1301.75). Control substances include all Schedule I, II, III, IV, and V substances listed in the CA Health and Safety Code, Sections 11053-11058, and do not need to be double locked. Personnel with authorized access to controlled substances include physicians, dentists, podiatrists, physician's assistants, licensed nurses and pharmacists. • **Security**: All drugs for dispensing are stored in an area that is secured at all times (CA B&P Code, §4172). Keys to locked storage area are available only to staff authorized by the physician to have access (16 CCR, Chapter 2, Division 13, Section 1356.3). The Medical Board of California interprets "all drugs" to also include both sample and over-the-counter drugs. The Medical Board defines "area that is secure" to mean a locked storage area within a physician's office. **Note**: During business hours, the drawer, cabinet or room containing drugs, medication supplies or hazardous substances may remain unlocked ***only*** if there is no access to area by unauthorized persons. Whenever drugs, medication supplies or hazardous substances are unlocked, authorized clinic personnel must remain in the immediate area ***at all times***. At all other times, drugs, medication supplies and hazardous substances must be securely locked. Controlled substances are locked at all times.

IV. Clinical Services - Pharmaceutical (continued on next page)

Pharmaceutical Services Survey Criteria	Yes	No	N/A	Wt.	Site Score
A. Drugs and medication supplies are maintained secure to prevent unauthorized access. CA B&P Code §4172; 22 CCR §75037(a-g), §75039; 21 CFR §1301.75, §1301.76, §1302.22; 16 CCR §1356.3					
1) Drugs are stored in specifically designated cupboards, cabinets, closets or drawers.	1)_____	1)_____	1)_____	1	
2) Prescription, sample and over-the counter drugs, hypodermic needles/syringes, prescription pads are securely stored in a lockable space (cabinet or room) within the office/clinic.	2)_____	2)_____	2)_____	1	
3) Controlled drugs are stored in a locked space accessible only to authorized personnel.	3)_____	3)_____	3)_____	1	
4) A dose-by-dose controlled substance distribution log is maintained.	4)_____	4)_____	4)_____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only

Criteria	IV. Clinical Services - Pharmaceutical Reviewer Guidelines
B. Drugs are handled safely and stored appropriately.	• **Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan. • **Drug preparation**: A drug or device is considered "adulterated" if it contains any filthy, putrid, or decomposed substance, or if it has been prepared, packed or held under unsanitary conditions (21 USC, Section 351). A drug is considered contaminated if it has been held under unsanitary conditions that may have been contaminated with filth, or rendered injurious to health. • **Storage**: Medications are kept separate from food, lab specimens, cleaning supplies, and other items that may potentially cause contamination. Drugs are stored under appropriate conditions of temperature, humidity, and light so that the identity, strength, quality, and purity of the drug product are not affected (21 CFR, Section 211.142). Room temperature where drugs are stored does not exceed 30ºC (86ºF) (Title 22, Section 75037 (d)). • **Immunobiologics**: Vaccines are refrigerated immediately upon receipt on site and stored according to specific instructions on the package insert for each vaccine. Diluent does not need refrigeration if vaccine is administered right after diluent is added. Vaccines are not stored in the doors of refrigerator or freezer. Refrigerator and freezer temperatures are documented at least once a day. Site personnel must be able to verbalize the procedure used to promptly respond to OUT OF RANGE TEMPERATURES. Contacting VFC or manufacturer are acceptable procedures. Refrigerator: Vaccines are kept in a refrigerator **maintained at 2-8ºC or 35-46ºF,** and include, but are not limited to, DTaP, Td, Tdap, Hepatitis A, Hepatitis B, IPV, Pneumococcal, Rotavirus, Hib, Influenza (inactivated and FluMist), MCV, HPV, Zoster, or any combinations of these listed vaccines. Freezer: Varicella and MMRV vaccines are stored in the **freezer at -15ºC or 5ºF, or lower,** and are protected from light at all times. MMR may be stored in a refrigerator or freezer; VFC recommends MMR be stored in the freezer with MMRV. If vaccines are in solid state and contain ice crystals on the outside of vial, they are considered appropriately frozen. • **Hazardous substances labeling**: Safety practices are followed in accordance with current/updated CAL-OSHA standards. The manufacturer's label is not removed from a container (bag, bottle, box, can, cylinder, etc.) as long as the hazardous material or residues of the material remain in the container. All portable containers of hazardous chemicals and secondary containers into which hazardous substances are transferred or prepared require labeling. Labels must provide the following information: 1) identity of hazardous substance, 2) description of hazard warning: can be words, pictures, symbols 3) date of preparation or transfer. • **Exception**: Labeling is not required for portable containers into which hazardous chemicals are transferred from labeled containers, and which are intended only for the immediate use of the individual who performs the transfer. **Note:** The purpose of hazard communication is to convey information about hazardous substances used in the work place. A hazardous substance is any substance that is a physical or health hazard. Examples of a physical hazard include substances that are a combustible liquid, a compressed gas, explosive, flammable, an organic peroxide, an oxidizer, pyrophoric, unstable (reactive) or water-reactive. Examples of a health hazard include substances where acute or chronic health effects may occur with exposure, such as carcinogens, toxic or highly toxic agents, irritants, corrosives, sensitizers and agents that damage the lungs, skin, eyes, or mucous membranes.

IV. Clinical Services - Pharmaceutical (continued on next page)

RN/MD Review only

Pharmaceutical Services Survey Criteria	Yes	No	N/A	Wt.	Site Score
B. Drugs are handled safely and stored appropriately. 22 CCR §75037(a-g), §75039; 21 CFR §211.137; 21 USC §351					
1) Drugs are prepared in a clean area, or "designated clean" area if prepared in a multipurpose room.	**1)**____	**1)**____	**1)**____	**1**	
2) Drugs for external use are stored separately from drugs for internal use.	**2)**____	**2)**____	**2)**____	**1**	
3) Items other than medications in refrigerator/freezer are kept in a secured, separate compartment from drugs.	**3)**____	**3)**____	**3)**____	**1**	
4) Refrigerator thermometer temperature is 35°-46° Fahrenheit or 2°-8° Centigrade (at time of site visit).	**4)**____	**4)**____	**4)**____	**1**	
5) Freezer thermometer temperature is 5° Fahrenheit or –15° Centigrade, or lower (at time of site visit).	**5)**____	**5)**____	**5)**____	**1**	
6) Daily temperature readings of medication refrigerator and freezer are documented.	**6)**____	**6)**____	**6)**____	**1**	
7) Drugs are stored separately from test reagents, germicides, disinfectants and other household substances.	**7)**____	**7)**____	**7)**____	**1**	
8) Hazardous substances are appropriately labeled.	**8)**____	**8)**____	**8)**____	**1**	
9) Site has method(s) in place for drug and hazardous substance disposal.	**9)**____	**9)**____	**9)**____	**1**	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

Criteria	IV. Clinical Services - Pharmaceutical Reviewer Guidelines
C. Drugs are dispensed according to State and federal drug distribution laws and regulations.	• **Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan. • **Expiration date**: The manufacturer's expiration date must appear on the labeling of all drugs. All prescription drugs not bearing the expiration date are deemed to have expired. If a drug is to be reconstituted at the time of dispensing, its labeling must contain expiration information for both the reconstituted and unconstituted drug. Expired drugs may not be distributed or dispensed. • **Prescription labeling**: Each prescription medication dispensed is in a container that is not cracked, soiled or without secure closures (Title 22, CCR, Section 75037 (a)). Drug container is labeled with the provider's name, patient's name, drug name, dose, frequency, route, quantity dispensed, and manufacturer's name and lot number. California Pharmacy Law *does not* prohibit furnishing a limited quantity of sample drugs if dispensed to the patient in the package provided by the manufacturer, no charge is made to the patient, and appropriate documentation is made in the patient's medical record (CA Business and Professions Code, Sections 4170, 4171). • **Drug distribution**: Each clinic that provides drug distribution services has written policies and procedures for the safe and effective distribution control, storage, use and disposition of drugs. • **Drug dispensing**: Drug dispensing is in compliance with all applicable State and federal laws and regulations. Drugs are dispensed only by a physician, pharmacist or other persons (e.g., NP, CNM, RN, PA) lawfully authorized to dispense medications upon the order of a licensed physician or surgeon. Personnel such as medical assistants, office managers, and receptionists do not dispense drugs. Drugs are not offered for sale, charged or billed to Medi-Cal members (Business and Professions Code, Article 13, Section 4193). A record of all drugs dispensed is entered in the patient's medical record. • **Vaccine Immunization Statements** (VIS): Since 1994, the National Childhood Vaccine Injury Act, Section 2126 of the Public Health Service Act, mandates that parents/guardians or adult patients be informed before vaccinations are administered. Health care providers must present and offer a copy of the most recent VIS to patients prior to any vaccine.* The date the VIS was given (or presented and offered) *and* the publication date of the VIS must be documented in the patient's medical record. The most current VIS are available from state and local health departments or can be downloaded from the CDC web site at http://www.cdc.gov/vaccines/pubs/vis/default.htm or by calling the CDC Immunization Hotline at (800) 232-2522. The Vaccines for Children (VFC) also contains current VIS and provider notifications at http://www.eziz.org/. *VIS published by CDC is to be provided to the patient/parent/guardian prior to administration of that vaccination. (42USC, 300aa-26(D)(2)). As of 2009, CDC allows providers to present a copy of the current VIS (such as a laminated copy in a binder, etc.) to the patient/parent/guardian and allow time for the patient to read and ask questions. Staff should also *offer* a copy each time (www.cdc.gov/vaccines/pubs/vis/vis-facts.htm). • **Pharmacy**: If a pharmacy is located on site, a licensed pharmacist monitors drug distribution and policies/procedures for medication dispensing/storage. **Note:** "Dispensing" of drugs means the furnishing of drugs or devices directly to a patient or upon a prescription from a physician, dentist, optometrist, podiatrist, veterinarian, or upon an order to furnish drugs or transmit a prescription from a certified nurse midwife, nurse practitioner, physician assistant or pharmacist acting within the scope of his or her practice.

IV. Clinical Services - Pharmaceutical (continued from previous page)

Pharmaceutical Services Survey Criteria	Yes	No	N/A	Wt.	Site Score
C. Drugs are dispensed according to State and federal drug distribution laws and regulations. CA B&P Code §4024, §4076, §4170, §4171, §4173, §4174; 22 CCR §75032, §75033, §75036, §75037(a-g), §75038, §75039; 16 CCR §1718.1; 21 CFR §211.137; 42 USC 6A §300AA-26					
1) There are no expired drugs on site.	**1)____**	**1)____**	**1)____**	**1**	
2) Site has a procedure to check expiration date of all drugs (including vaccines and samples), and infant and therapeutic formulas.	**2)____**	**2)____**	**2)____**	**1**	
3) All stored and dispensed prescription drugs are appropriately labeled.	**3)____**	**3)____**	**3)____**	**1**	
4) **Only lawfully authorized persons dispense drugs to patients.**	**4)____**	**4)____**	**4)____**	**2**	
5) Current Vaccine Information Sheets (VIS) for distribution to patients are present on site.	**5)____**	**5)____**	**5)____**	**1**	
6) If there is a pharmacy on site, it is licensed by the CA State Board of Pharmacy.	**6)____**	**6)____**	**6)____**	**1**	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

Criteria	IV. Clinical Services – Laboratory Reviewer Guidelines
D. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations.	• **CLIA Certificates**: All sites that perform laboratory testing for human health assessment, diagnosis, prevention, or treatment of disease has a current, unrevoked, unsuspended site-specific Clinical Laboratory Improvement Amendment (CLIA) certificate, or evidence of renewal. Acceptable documentation such as the original certificate, copy of the original certificate, renewal receipt or other evidence of renewal submission is present on site or readily available upon request. The CLIA certificate or evidence of renewal should include the current site/clinic address. Note: Per 42 CFR, 493.35(b)(1-3), 493.43(b)(1-3) and 493.55(b)(1-3), laboratories must file a separate application for each laboratory location, with the following *exceptions*: 1) Laboratories that are not at a fixed location, that is, laboratories that move from testing site to testing site, such as mobile units providing laboratory testing, health screening fairs, or other temporary testing locations may be covered under the certificate of the designated primary site or home base, using its address, 2) Not-for-profit or Federal, State, or local government laboratories that engage in limited (not more than a combination of 15 moderately complex or waived tests per certificate) public health testing may file a single application, or 3) Laboratories within a hospital that are located at contiguous buildings on the same campus and under common direction may file a single application or multiple applications for laboratory sites within same physical location or street address. The CLIA Certificate on site includes one of the following: A) Certificate of Waiver: Site is able to perform only exempt waived tests. B) Certificate for Provider-Performed Microscopy (PPM): Physicians, dentists, or mid-level practitioners are able to perform PPM procedures and waived tests. C) Certificate of Registration: Allows moderate and/or high complexity lab testing to be conducted until compliance with CLIA regulations are determined by survey. D) Certificate of Compliance: Lab has been surveyed and found in compliance with all applicable CLIA requirements. E) Certificate of Accreditation: Lab is accredited by an accreditation organization approved by the Centers for Medicare & Medicaid Services (CMS). • **Waived tests**: If only waived tests are performed, site has a current CLIA Certificate of Waiver. There are no specific CLIA regulations regarding the performance of waived tests. Site personnel are expected to follow the test manufacturer's instructions. Laboratories with certificates of waiver may not be routinely inspected by DHCS Laboratory Field Services Division, but may be inspected as part of complaint investigations and on a random basis to determine whether only waived tests are being performed. • **Moderate and High complexity tests**: Tests not listed as waived are divided into one of two categories, moderate complexity or high complexity, based on the complexity of the testing procedure. CLIA regulations for these categories list specific requirements for laboratory proficiency testing, patient test management, quality control, quality assurance, personnel, and inspections. • **Personnel training:** Prior to testing biological specimens, personnel have been appropriately trained for the type and complexity of the laboratory services performed. Personnel have demonstrated the ability to perform all testing operations reliably and to report results accurately. Site personnel that perform CLIA waived tests have access to and are able to follow test manufacturer's instructions. When requested, site personnel are able to provide a step-by-step verbal explanation or demonstration of test procedure and how to determine test results. The required training and certification is established by legislation (CA B&P Codes, §1200-1213) for personnel performing moderate and high complexity tests. Reviewers are not expected to complete an in-depth evaluation of personnel performing moderate and high complexity tests. **Note:** Any site that performs tests or examinations on human biological specimens derived from the human body is, by definition, "laboratories" under State and federal law, and includes locations such as nurses' stations within hospitals, clinics, surgical centers, physician offices, and health fairs. The current listing of waived tests may be obtained at www.fda.gov/cdrh/clia/testswaived.html. CLIA re/certification includes an evaluation every two years (or sooner of complaint driven) by CDPH of personnel licenses/training, laboratory site inspection and demonstration of testing proficiency for moderate and high-complexity test sites. **Contact CDPH Laboratory Field Services (510) 620-3800 for CLIA certification, laboratory license, or personnel questions.**

IV. Clinical Services - Laboratory

Laboratory Services Survey Criteria	Yes	No	N/A	Wt.	Site Score
D. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations. 17 CCR §1050; 22 CCR §51211.2, §51137.2; B&P Code §1220; 42 USC 263a; Public Law 100-578					
1) Laboratory test procedures are performed according to current site-specific CLIA certificate.	1)_____	1)_____	1)_____	1	
2) Testing personnel performing clinical lab procedures have been trained.	2)_____	2)_____	2)_____	1	
3) Lab supplies (e.g. vacutainers, vacutainer tubes, culture swabs, test solutions) are inaccessible to unauthorized persons.	3)_____	3)_____	3)_____	1	
4) Lab test supplies are not expired.	4)_____	4)_____	4)_____	1	
5) Site has a procedure to check expiration date and a method to dispose of expired lab test supplies.	5)_____	5)_____	5)_____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

Criteria	IV. Clinical Services - Radiology Reviewer Guidelines
E. Site meets CDPH Radiological inspection and safety regulations.	• **CDPH Radiologic Health Branch (RHB) Inspection Report**: If site has ***current*** documentation of one of the following, give the full 9 points and survey items 2-9 will not need to be surveyed. 1) Inspection Report, ***or*** 2) Inspection Report *and* Short Form Sign-off sheet, ***or*** 3) Inspection Report *and* Notice of Violation form *and* approval letter for corrective action plan from the CA RHB. The Radiologic Inspection Report, issued by the RHB, must be present if there is radiology equipment on site. If any violations are found, one of two documents is issued to the site. The "Short Form Sign-off sheet" is issued for minimal problems that are easily corrected. The "Notice of Violation" form, requiring a site corrective action plan, is issued if there are more serious violations. All "Notice of Violation" corrective action plans must be accompanied by an approval letter from the CA RHB. **If documents are not available on site, or if reviewer is uncertain about the "current" status of documents on site, proceed to score all items 1-9.** • **Radiological equipment**: Equipment inspection, based on a "priority" rating system, is established by legislation (CA H&S Code, Section 115115). 1) Mammography equipment is inspected annually (Mammography Quality Standards Act, 21 CFR, Section 900), and must have federal FDA Certification on site ***and*** CA Mammography X-ray Equipment and Facility Accreditation Certification posted on the machine. 2) High Priority equipment (e.g. fluoroscopy, portable X-ray) is inspected every three years. 3) Medium Priority equipment is inspected every 4-5 years depending on the volume of patients, frequency of x-ray equipment use, and likelihood of radiation exposure. If reviewer is uncertain about the "current" status of equipment inspection, call the Radiological Health Branch. • **Radiology Personnel**: All certificates/licenses are posted and show expiration dates. If there are a large number of technicians, a list of names, license numbers, and expiration dates may be substituted. The Certified Radiological Technologist (CRT) certificate permits the technologist to perform all radiology films except mammography and fluoroscopy, which require separate certificates. The "Limited Permit" limits the technician to one of the ten (10) x-ray categories specified on the limited certificate: Chest, Dental laboratory, Dermatology, Extremities, Gastrointestinal, Genitourinary, Leg-podiatric, Skull, Torso-skeletal, and X-ray bone densitometry. Note: Per RHB, dexascanners do not require lead aprons or gonadal shields, however, criteria 1-7 are still required. RHB uses the ALARA (As Low As Reasonably Achievable) principle, which is the foundation of all radiation safety programs. The ALARA principle means to minimize exposure to radiation doses by employing all *reasonable* methods. Dexascanner manufacturer guidelines do not require gonadal shielding or lead aprons because the amount of radiation is very low, and there is potential for the shield to obscure the area being scanned, which could render the scan non-diagnostic. Operators do not need aprons because the beam is extremely focused, so that the amount of exposure of even "scattered" beams to an operator sitting at a seat near the scanner is about the same level as that found in the natural environment. (A traditional x-ray machine used for bone density testing, that is not a dexascanner, *may* require shielding/apron.) **Note:** The Radiologic Health Branch of the Food, Drug, and Radiation Safety Division of the CA Department of Public Health enforces the Radiation Control Laws and Regulations designed to protect both the public and employees against radiation hazards. Enforcement is carried out through licensing, registration and periodic inspection of sources of radiation, such as radiation machines. For questions regarding radiologic safety (e.g. expired or no inspection letters on site), call CDPH Radiologic Health Branch at (916) 327-5106, or for general information at (916) 440-7888. For Radiation Emergency Assistance, call 1-800-*852*-7550. Ref: CCR, Title 17, Chapter 5, Subchapter 4 regulations at www.cdph.ca.gov/programs/Pages/RadiologicHealthBranch.aspx

IV. Clinical Services - Radiology

Radiology Services Survey Criteria	Yes	No	N/A	Wt.	Site Score
E. Site meets CDPH Radiological inspection and safety regulations. 17 CCR §30255, §30305, §30404, §30405					
1) Site has current CA Radiologic Health Branch Inspection Report, if there is radiological equipment on site.	**1)____**	**1)____**	**1)____**	**1**	
The following documents are <u>posted</u> on site: 2) Current copy of Title 17 with a posted notice about availability of Title 17 and its location	**2)____**	**2)____**	**2)____**	**1**	
3) "Radiation Safety Operating Procedures" posted in highly visible location.	**3)____**	**3)____**	**3)____**	**1**	
4) "Notice to Employees Poster" posted in highly visible location.	**4)____**	**4)____**	**4)____**	**1**	
5) "Caution, X-ray" sign posted on or next to door of each room that has X-ray equipment	**5)____**	**5)____**	**5)____**	**1**	
6) Physician Supervisor/Operator certificate posted *and* within current expiration date	**6)____**	**6)____**	**6)____**	**1**	
7) Technologist certificate posted *and* within current expiration date	**7)____**	**7)____**	**7)____**	**1**	
The following radiological protective equipment is present on site: 8) Operator protection devices: radiological equipment operator must use lead apron or lead shield.	**8)____**	**8)____**	**8)____**	**1**	
9) Gonadal shield (0.5 mm or greater lead equivalent): for patient procedures in which gonads are in direct beam.	**9)____**	**9)____**	**9)____**	**1**	
Comments: Write comments for all "No" (0 points) and "N/A" scores.					

Criteria	V. Preventive Services Reviewer Guidelines
A. Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases.	• **Examination table**: A protective barrier that is changed between patient contact is used to cover exam table surface. "Good repair" means clean and well maintained in proper working order. • **Scales**: Infant scales are marked and accurate to increments of one (1) ounce or less, and have a capacity of at least 35 pounds. Standing floor scales are marked and accurate to increments of one-fourth (1/4) pound or less, and have a capacity of at least 300 pounds. Balance beam or electronic scales are appropriate for clinic use. Balance scales have an adjustment mechanism and zeroing weight to enable routine balancing at zero. Electronic or digital scales have automatic zeroing and lock-in weight features. Spring balance scales (e.g. bathroom scales) are unsatisfactory for clinical use because, over time, the spring counter balance mechanism loses its accuracy. • **Measuring devices**: Equipment on site for measuring stature (length/height) and head circumference includes: 1) rigid 90º right angle headboard block that is perpendicular to the recumbent measurement surface, or vertical to the wall-mounted standing measurement surface. 2) flat, paper or plastic non-stretchable tape or yardstick, marked to one-eighth (1/8 in. or 1 mm) or less, attached to a firm, flat surface. The "0" of the tape is exactly at the base of the headboard for recumbent measurement, or exactly at foot level for standing measurement. 3) moveable, non-flexible foot board at 90º right angle perpendicular to the recumbent measurement surface, or a flat floor surface for standing. 4) A non-stretchable tape measuring devise marked to one-eighth (1/8 in. or 1 mm) or less for measuring head circumference. • **Basic equipment**: Exam gown sizes are appropriate to population served on site. • **Vision testing**: Site has both a literate (e.g., Snellen) and an illiterate eye chart (e.g., "E" Chart, "Kindergarten" chart, Allen Picture Card Test). "Heel" lines are aligned with center of eye chart at a distance of 10 or 20-feet depending on whether the chart is for the 10-foot or 20-foot distance. Eye charts are located in an area with adequate lighting and at height(s) appropriate to use. Disposable eye "occluders" (e.g., Dixie cups or tongue blades with back-to-back- stickers) are acceptable. Non-disposable occluders are cleaned between patients. • **Hearing testing:** Offices that provide pediatric preventive services should have an audiometer available since audiometric testing is required at preventive health visits starting at 3 years of age. PCP offices (such as Family Practitioners or General Practitioners) with less than 15% of their patients that are pediatric, and that refer all members to another provider for audiometric testing, must have a system in place that clearly demonstrates that the PCP office verifies that audiometric testing has been completed and that those results are returned to the PCP for review. **Note:** Although patient population varies from site-to-site, screening equipment listed in this section is the standard equipment most often used in performing a physical health screening examination for children and adults.

V. Preventive Services (continued on next page)

Preventive Services Survey Criteria	Yes	No	N/A	Wt.	Site Score
A. Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases. 22 CCR §53851, §56210; 28 CCR §1300.67 Examination equipment, appropriate for primary care services, is available on site:					
1) Exam tables and lights are in good repair.	1)_____	1)_____	1)_____	1	
2) Stethoscope and sphygmomanometer with various size cuffs (e.g. child, adult, obese/thigh).	2)_____	2)_____	2)_____	1	
3) Thermometer with a numeric reading.	3)_____	3)_____	3)_____	1	
4) Scales: standing balance beam and infant scales.	4)_____	4)_____	4)_____	1	
5) Measuring devices for stature (height/length) measurement *and* head circumference measurement.	5)_____	5)_____	5)_____	1	
6) Basic exam equipment: percussion hammer, tongue blades, patient gowns.	6)_____	6)_____	6)_____	1	
7) Eye charts (literate and illiterate) and occluder for vision testing.	7)_____	7)_____	7)_____	1	
8) Ophthalmoscope.	8)_____	8)_____	8)_____	1	
9) Otoscope with adult and pediatric ear speculums.	9)_____	9)_____	9)_____	1	
10) Audiometer in quiet location for testing.	10)____	10)____	10)____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only

Criteria	V. Preventive Services Reviewer Guidelines
B. Health education services are available to Plan members.	• **Health Education services:** Services may include individual instruction, group classes, family counseling and/or other health educational programs and materials provided to members by the provider, health plan, or community sponsored programs. • **Health Education materials:** Materials must be available in the appropriate threshold languages**,** and may be located in an accessible area on site (e.g., exam room, waiting room, health education room or area), or provided to members by clinic staff and/or by Plan upon request. Materials may include written information, audio and/or videotapes, computerized programs, and visual presentation aids. General topics for health educational materials may include Immunizations, Pregnancy, Injury Prevention, Smoking Cessation, Dental Health, Nutrition, Physical Activity, STD/HIV Prevention, Family Planning, Asthma, Hypertension, and Diabetes. • **Plan-specific Referral information:** Plan-specific informing materials and/or resources are available on site in languages that are applicable to member population(s) primarily seen on site. For example, if primarily English and Spanish-speaking members are seen on site, then Plan-specific informing materials are available on site in those languages. Although a site may not stock informing materials in ***each*** threshold language identified for the county, site personnel has access to contact resource information for locating Plan-specific informing materials in threshold languages not typically seen on site. Interpreter services are provided in all identified threshold and concentration standard languages. **Note:** Threshold languages are the primary languages spoken by Limited English Proficient (LEP) population groups residing in a county. A numeric threshold of 3,000 eligible LEP Medi-Cal beneficiaries, or a concentration standard of 1,000 residing in a single ZIP code or 1,500 in two contiguous ZIP codes establishes the threshold languages identified by DHCS for each county.

V. Preventive Services (continued from previous page)

RN/MD Review only

Health Education Survey Criteria	Yes	No	N/A	Wt.	Site Score
B. Health education services are available to Plan members. 22 CCR §53851; 28 CCR 1300.67					
Health education materials and Plan-specific resource information are: 1) readily accessible on site, or are made available upon request,	1)_____	1)_____	1)_____	1	
2) applicable to the practice and population served on site,	2)_____	2)_____	2)_____	1	
3) available in threshold languages identified for county and/or area of site location.	3)_____	3)_____	3)_____	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores.					
Totals					

RN/MD Review only

Criteria	VI. Infection Control Reviewer Guidelines
A. Infection control procedures for Standard/Universal precautions are followed.	• **Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan. • **Hand washing facilities**: Hand washing facilities are available in the exam room and/or utility room, and include an adequate supply of running potable water, soap and single use towels or hot air drying machines. Sinks with a standard faucet, foot-operated pedals, 4-6-inch wing-type handle, automatic shut-off systems or other types of water flow control mechanism are acceptable. Staff is able to demonstrate infection control "barrier" methods used on site to prevent contamination of faucet handle, door handles and other surfaces until hand washing can be performed. On occasions when running water is not readily available, an antiseptic hand cleanser, alcohol-based hand rub, or antiseptic towelettes is acceptable until running water is available (29 CFR 1919.1030). • **Antiseptic hand cleaner**: Hand washing prevents infection transmission by removing dirt, organic material and transient microorganisms from hands. Hand washing with plain (non-antimicrobial) soap in any form (e.g., bar, leaflet, liquid, powder, granular) is acceptable for general patient care (Association for Professionals in Infection Control and Epidemiology, Inc., 1995). Antimicrobial agents or alcohol-based antiseptic hand rubs are used for hand washing when indicated to remove debris and destroy transient microorganisms (e.g., before performing invasive procedures, after contact with potentially infectious materials). Plain and antiseptic hand wash products are properly maintained and/or dispensed to prevent contamination. • **Waste disposal container**: Contaminated wastes (e.g. dental drapes, band aids, sanitary napkins, soiled disposal diapers) are disposed of in regular solid waste (trash) containers, and are maintained to prevent potential contamination of patient/staff areas and/or unsafe access by infants/children. Closed containers are not required for regular, solid waste trash containers. • **Isolation procedures**: Personnel are able to demonstrate or verbally explain procedure(s) used on site to isolate patients with potentially contagious conditions from other patients. If personnel are unable to demonstrate or explain site-specific isolation procedures *and* cannot locate written isolation procedure instructions, site is considered deficient. Isolation procedures will vary from site to site. **Note:** Infection Control standards are practiced on site to minimize risk of disease transmission. Site personnel are expected to apply the principles of "Standard Precautions" (CDC, 1996), used for all patients regardless of infection status. Standard precautions apply to blood, all body fluids, non-intact skin, and mucous membranes, which are treated as potentially infectious for HIV, HBV or HCV, and other bloodborne pathogens. "Universal precautions" refer to the OSHA mandated program that requires implementation of work practice controls, engineering controls, bloodborne pathogen orientation/education, and record keeping in healthcare facilities.

VI. Infection Control (continued on next page)

RN/MD Review only

Infection Control Survey Criteria	Yes	No	N/A	Wt.	Site Score
A. Infection control procedures for Standard/Universal precautions are followed. 8 CCR §5193; 22 CCR §53230; 29 CFR §1910.1030; Federal Register 1989, §54:23042					
1) Antiseptic hand cleaner and running water are available in exam and/or treatment areas for hand washing.	**1)_____**	**1)_____**	**1)_____**	**1**	
2) A waste disposal container is available in exam rooms, procedure/treatment rooms and restrooms.	**2)_____**	**2)_____**	**2)_____**	**1**	
3) Site has procedure for effectively isolating infectious patients with potential communicable conditions.	**3)_____**	**3)_____**	**3)_____**	**1**	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only **VI . Infection Control Reviewer Guidelines – B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act.**

- **Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan.
- **Personal Protective Equipment (PPE):** PPE for protection against bloodborne pathogen hazards is available on site and includes: water repelling gloves; clothing barrier/gown; face/eye protection (e.g., goggles/face shield); and respiratory infection protection (e.g., mask). It does not include general work clothes (e.g., uniforms, cloth lab coats) that permit liquid to soak through. General work clothes are appropriate only if blood/OPIM does not penetrate through employee's work clothes, undergarments, skin, eyes, mouth, or other mucous membranes under NORMAL conditions of use.
- **Blood and Other Potentially Infectious Materials (OPIM):** OPIM are all human body fluids, any unfixed tissue or organ (other than intact skin) from a human (living or dead), and HIV or HBV-containing blood, cells, tissue, organs, cultures, medium or solutions. Containers for blood and OPIM are closable, leak proof, and labeled and/or color-coded. Double bagging is required only if leakage is possible.
- **Labels:** A warning label is affixed to red bagged regulated wastes, sharps containers, refrigerators/freezers containing blood or OPIM, containers used to store or transport blood or OPIM, and contaminated laundry or equipment for storage or transporting. The international biohazard symbol with word "BIOHAZARD" *or* the words "Biohazardous Waste" label (fluorescent orange or red-orange with contrasting lettering/symbols) is part of, or affixed to, the container. Sharps containers are labeled with the words "Sharps Waste" or with the international biohazard symbol and the word "BIOHAZARD". Individual containers of blood or OPIM are exempted from warning labels if placed inside a labeled secondary container for storage, transport, or disposal. Alternative marking or color coding may be used to label contaminated laundry or specimen containers if the alternative marking permits employees on site to recognize that container requires compliance with Universal Precautions.
- **Needlestick Safety:** Contaminated sharps are discarded immediately. Sharps containers are located close to the immediate area where sharps are used, and are inaccessible to unauthorized persons. Sharps are not bent, removed from a syringe, or recapped except by using a one-handed technique. Needleless systems, needles with Engineered Sharps Injury Protection (ESIP) devices, and non-needle sharps are used (incl. in emergency kits), unless exemptions have been approved by Cal/OSHA (8CCR, Section 5193). Security of portable containers in patient care areas is maintained at all times. Any device capable of cutting or piercing (e.g. syringes, hypodermic needles, needleless devices, blades, broken glass, slides, vials) are placed in a closable, puncture-resistant, labeled, leak-proof container. If these requirements are met, containers made of various materials (e.g., cardboard, plastic) are acceptable. Containers are not overfilled past manufacturer's designated fill line, or more than ¾ full. Supply of containers on hand is adequate to ensure routine change-out when filled.
- **Sharps Injury documentation:** Site has a method in place to document sharps injuries. Date, time, description of exposure incident, sharp type/brand, follow-up care is documented within 14 days of injury incident.
- **Contaminated Laundry:** Contaminated laundry (soiled with blood/OPIM) is laundered by a commercial laundry service, or a washer and dryer on site. Contaminated laundry should not contain sharps, and when transported, should have the appropriate warning label (see Labels bullet above). Manufacturer's guidelines are followed to decontaminate and launder reusable protective clothing. Laundry requirements are "not applicable" if only disposable patient gowns and PPE are used on site.
- **Regulated Waste storage:** Regulated wastes include: 1) **Biohazardous wastes**, e.g., laboratory wastes, human specimens/tissue, blood/contaminated materials "known" to be infected with highly communicable diseases for humans and/or that require isolation, and 2) **Medical wastes**, e.g., liquid/semi-liquid blood or OPIM, items caked with dry blood or OPIM and capable of releasing materials during handling, and contaminated sharps. Regulated waste is contained separately from other wastes (e.g., contaminated wastes)* *and* placed in red biohazardous bags with Biohazard label, and stored in a closed container that is not accessible to unauthorized persons. If stored outside the office, a lock secures the entry door, gate or receptacle lid, and posted warning sign(s) in English *and* Spanish are visible for 25-feet: "**CAUTION-BIOHAZARDOUS WASTE STORAGE AREA- UNAUTHORIZED PERSONS KEEP OUT" or "CUIDADO-ZONA DE RESIDUOUS-BIOLOGICOS PELIGOROS-PROHIBIDA LE ENTRADA A PERSONAS NO AUTHORIZADAS."** Signs prior to the passage of the Medical Waste Act are permitted for the "life" of the sign.
- **Medical Waste disposal:** Medical wastes are hauled to a permitted offsite medical waste treatment facility, transfer station, or other registered generator by a registered hazardous waste transporter *OR* person with an approved limited-quantity hauling exemption granted by the CDPH Division of Drinking Water and Environmental Management Branch. Limited-quantity hauling exemptions are renewed annually. A medical waste tracking document that includes the name of the person transporting, number of waste containers, types of medical wastes, and date of transportation, is kept a minimum of 3 years for large waste generators and 2 years for small generators. Medical Waste (including sharps) transported by mail are only acceptable through vendors on the approved CDPH Mail Back Service List at: www.cdph.ca.gov/certlic/medicalwaste/Documents/MedicalWaste/SharpsMailBackList.pdf .

Ref: CDPH Medical Waste Management Program: www.cdph.ca.gov/certlic/medicalwaste/Pages/Contact.aspx or www.cdph.ca.gov/certlic/medicalwaste/Pages/default.aspx.
The full CA Medical Waste Management Act (H&SC 117600-11836) is at www.cdph.ca.gov/certlic/medicalwaste/Documents/MedicalWaste/MedicalWasteManagementAct.pdf

***Note:** Contaminated wastes include materials soiled with blood during the course of their use but are not within the scope of regulated wastes. Contaminated waste items need not be disposed as regulated waste in labeled red bags, but can be discarded as solid waste in regular trash receptacle.

VI. Infection Control (continued on next page)

RN/MD Review only

Infection Control Survey Criteria	Yes	No	N/A	Wt.	Site Score
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. 8 CCR §5193 (Cal OSHA Health Care Worker Needlestick Prevention Act, 1999); H& S Code, §117600-118360 (CA Medical Waste Management Act, 1997); 29 CFR §1910.1030.					
1) **Personal Protective Equipment is readily available for staff use.**	1)_____	1)_____	1)_____	2	
2) **Needlestick safety precautions are practiced on site.**	2)_____	2)_____	2)_____	2	
3) All sharp injury incidents are documented.	3)_____	3)_____	3)_____	1	
4) **Blood, other potentially infectious materials and Regulated Wastes are placed in appropriate *leak proof, labeled* containers for collection, handling, processing, storage, transport or shipping.**	4)_____	4)_____	4)_____	2	
5) Biohazardous (non-sharp) wastes are contained separate from other trash/waste.	5)_____	5)_____	5)_____	1	
6) Contaminated laundry is laundered at the workplace or by a commercial laundry service.	6)_____	6)_____	6)_____	1	
7) Storage areas for regulated medical wastes are maintained secure and inaccessible to unauthorized persons.	7)_____	7)_____	7)_____	1	
8) Transportation of regulated medical wastes is only by a registered hazardous waste hauler or by a person with an approved limited-quantity exemption.	8)_____	8)_____	8)_____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only

Criteria	VI. Infection Control Reviewer Guidelines
C. Contaminated surfaces are decontaminated according to Cal-OSHA standards.	• **Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan. • **Routine Decontamination**: Contaminated work surfaces are decontaminated with an appropriate disinfectant (29 CFR 1910.1030). Written "housekeeping" schedules have been established and are followed for regular routine daily cleaning. Staff is able to identify frequency for routine cleaning of surfaces and equipment, the disinfectant used and responsible personnel. • **Spill Procedure**: Staff is able to identify procedures for prompt decontamination of blood/body fluid spills, the disinfectant used, and the responsible person(s). • **Disinfectant Products**: Products used for decontamination have a current EPA-approved status. Effectiveness in killing HIV/HBV/TB is stated on the manufacturer's product label. Decontamination products are reconstituted and applied according to manufacturer's guidelines for "decontamination." • **10% Bleach Solution**: 10% bleach solution that is EPA registered, effective against TB, is changed/reconstituted ***every*** 24 hours (due to instability of bleach once mixed with water). Surface is cleaned prior to disinfecting (due to presence of organic matter (e.g., dirt, blood, excrement) inactivates active ingredient, sodium hypochlorite). Surface is air dried or allowed appropriate time (stated on label) before drying. Manufacturer's directions, *specific* to every bleach product, are followed carefully. **Note:** "Contamination" means the presence or reasonably anticipated presence of blood or OPIM on any item or surface. "Decontamination" is the use of appropriate physical or chemical means to remove, inactivate or destroy bloodborne pathogens so that a surface or item is no longer capable of transmitting infectious particles and is rendered safe for handling, use or disposal. Current EPA product lists and information is available from the EPA, Antimicrobial Division at (703) 305-1284, or at www.epa.gov/oppad001/chemregindex.htm.

VI. Infection Control (continued on next page)

RN/MD Review only

Infection Control Survey Criteria	Yes	No	N/A	Wt.	Site Score
C. Contaminated surfaces are decontaminated according to Cal-OSHA Standards. 8 CCR §5193; CA H&S Code §118275					
1) Equipment and work surfaces are appropriately cleaned and decontaminated after contact with blood or other potentially infectious material.	**1)____**	**1)____**	**1)____**	**1**	
2) Routine cleaning and decontamination of equipment/work surfaces is completed according to site-specific written schedule.	**2)____**	**2)____**	**2)____**	**1**	
Disinfectant solutions used on site are: 3) approved by the Environmental Protection Agency (EPA).	**3)____**	**3)____**	**3)____**	**1**	
4) effective in killing HIV/HBV/TB.	**4)____**	**4)____**	**4)____**	**1**	
5) used according to product label for desired effect.	**5)____**	**5)____**	**5)____**	**1**	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only

Criteria	VI. Infection Control Reviewer Guidelines
D. Reusable medical instruments are properly sterilized after each use.	• **Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan. • **Cleaning prior to sterilization**: Prior to undergoing the sterilization process, soiled instruments/equipment are thoroughly cleaned, rinsed, dried and inspected for the presence of dried blood or other debris. Personnel are able to demonstrate or verbally explain procedure(s) used for cleaning prior to sterilization, and to locate written directions on site. • **Cold/chemical sterilization**: Product manufacturer's directions are strictly followed for instrument pre-soaking treatment, solution preparation, solution exposure procedures, safety precautions (e.g., room temperature, area ventilation), and post-sterilization processes. Sterilization exposure times and solution expiration date/time is communicated to staff. Written procedures for cold sterilization are available on site to staff. • **Autoclave/steam sterilization**: Autoclave manufacturer's directions are strictly followed for instrument pre-cleaning, machine loading, operation safety precautions, minimum time-temperature criteria, and post sterilization processes. Written operating procedures for autoclave are available on site to staff. Documentation of sterilization loads includes: date, time and duration of run cycle, temperature, steam pressure, and operator of each run. If instruments/equipment are transported off-site for sterilization, equipment-handling and transport procedures are available on site to staff. • **Autoclave maintenance**: Autoclave is maintained and serviced according to manufacturer's guidelines. Documentation of maintenance should include: mechanical problems, inspection dates, results/outcome of routine servicing, calibration, repairs, etc. Note: If the manufacturer's guidelines are not present on site, then the autoclave is serviced annually by a qualified technician. A dated sticker on the autoclave or a service receipt is acceptable documentation of appropriate maintenance. • **Spore testing**: Autoclave spore testing is performed *at least monthly*, unless otherwise stated in manufacturer's guidelines. Documentation of biological spore testing includes: date, results, types of spore test used, person performing/documenting test results. Written procedures for performing routine spore testing and for handling positive spore test results are available on site to staff. For positive spore tests, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs. Procedures include: ***report*** problem, ***repair*** autoclave, ***retrieve*** all instruments sterilized since last negative spore test, ***re-test*** autoclave and ***re-sterilize*** retrieved instruments (**R**eport/**R**epair/**R**etrieve/**R**etest/**R**e-sterilize). **Note:** Sterilization methods include autoclaves (steam under pressure), Ethylene Oxide (EO) gas sterilizer, dry-heat sterilizer, and liquid chemical sterilants. Biologic spore test products vary, and are designed for use based on specific autoclave type. Biologic control testing challenges the autoclave sterilization cycle with live, highly resistant, nonpathogenic spores. If spores are killed during processing, it is assumed that all other microorganisms are also killed and that the autoclave load is sterile. • **Sterile Packages**: Storage areas for sterilized packages are clean, dry and separated from non-sterile items by a functional barrier (e.g., shelf, cabinet door, and drawer). Sterilized package labels include date of sterilization, load run identification information, and general contents (e.g. suture set). Each item in a sterile package need not be listed on the label if a master list of package contents is available elsewhere on site. Maintenance of sterility is event related, not time related. Sterilized items are considered sterile until use, unless an event causes contamination. Sterilized items are not considered sterile if package is opened, wet/moist, discolored or damaged, and should be kept removed from sterile package storage area. Site has a process for routine evaluation of sterilized packages.

VI. Infection Control (continued from previous page)

RN/MD Review only

Infection Control Survey Criteria	Yes	No	N/A	Wt.	Site Score
D. Reusable medical instruments are properly sterilized after each use. 22 CCR §53230, §53856					
1) Written site-specific policy/procedures or Manufacturer's Instructions for instrument/equipment sterilization are available to staff.	1)_____	1)_____	1)_____	1	
Staff adheres to site-specific policy and/or manufacturer/product label directions for the following procedures:					
2) Cleaning reusable instruments/equipment prior to sterilization	2)_____	2)_____	2)_____	1	
3) Cold chemical sterilization	3)_____	3)_____	3)_____	1	
4) Autoclave/steam sterilization	4)_____	4)_____	4)_____	1	
5) Autoclave maintenance	5)_____	5)_____	5)_____	1	
6) **Spore testing of autoclave/steam sterilizer with documented results (at least monthly)**	6)_____	6)_____	6)_____	2	
7) Sterilized packages are labeled with sterilization date and load identification information.	7)_____	7)_____	7)_____	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores.					
Totals					

Full Scope **Attachment B**

Medical Record Review Survey 2012

California Department of Health Care Services

No. of Physicians _____

Health Plan_____ IPA _____Site No._____ Review Date _____ No. of Records_____

Provider _____ Phone _____ Fax _____

Address_____ Contact person/title _____

City/Zip Code_____ Reviewer/title _____

Visit Purpose	Site-Specific Certification(s)	Provider Type	Clinic type
_____ Initial Full Scope _____ Monitoring	_____ AAAHC _____ JCAHO	_____ Family Practice _____ Internal Medicine	_____ Primary Care _____ Community
_____ Periodic Full Scope _____ Follow-up	_____ CHDP _____ NCQA	_____ Pediatrics _____ OB/GYN	_____ Hospital _____ FQHC
_____ Focused Review _____ Ed/TA	_____ CPSP _____ None	_____ General Practice _____ Specialist	_____ Rural Health _____ Other _____ (type)
_____Other _____ (type)	_____ Other _____	_____ Mid-level (type)_____	_____ Solo _____ Group _____ Staff/Teaching

Scoring Procedure

Note: Score only one Preventive section (Pediatric, Adult or OB/CPSP) per record. When scoring for OB/CPSP Preventive, do not score the Adult or Pediatric Preventive for that same record**.**

	Points possible	Yes Pts. Given	No's	N/A's	Section Score %
I. Format	**(8) x 10 = 80**				
II. Documentation	**(7) x 10 = 70**				
III. Continuity/Coordination	**(8) x 10 = 80**				
IV. Pediatric Preventive	**(19) x # of records**				
V. Adult Preventive	**(15) x # of records**				
VI. OB/CPSP Preventive	**(20) x # of records**				
	Total Points Possible	**Yes Pts. Given**	**No's**	**N/A's**	

Medical Record Scores

Scoring is based on **10** medical records.

1) Add points given in each section.
2) Add points given for all six (6) sections.
3) Subtract "N/A" points (if any) from total points possible to get "adjusted" total points possible.
4) Divide total points given by "adjusted" total points possible.
5) Multiply by 100 to determine compliance rate as a percentage.

_____ ÷ _____ = _____ **x 100** = _____%

Points Given / Total/ Adjusted Pts. Poss. / Decimal Score / Compliance Rate

Note: Since Preventive Criteria have different points possible per type (Ped-19, Adult-15, OB/CPSP-20), the total points possible will differ from site to site, depending on the number of *types* of records that are selected. The "NO" column *may* be used to help double-check math. The far right Section Score % column may be used to determine if section is <80%.

Compliance Rate

Note: Any section score of < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

___**Exempted Pass: 90% or above:** (Total score is ≥ 90% *and* all section scores are 80% or above)

__ **Conditional Pass: 80-89%:** (Total MRR is 80-89% *OR* *any* section(s) score is < 80%)

__**Not Pass: Below 80%**

__CAP Required

__Other follow-up

Next Review Due: _____

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Medical Record Review Guidelines 2012

California Department of Health Care Services
Medi-Cal Managed Care Division

Purpose: Medical Record Survey Guidelines provide standards, directions, instructions, rules, regulations, perimeters, or indicators for the medical record survey, and shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions.

Scoring: Survey score is based on a review standard of 10 records per individual primary care physician (PCP). Documented evidence found in the hard copy (paper) medical records and/or electronic medical records, including immunization registries, are used for survey criteria determinations. An Exempted Pass is 90%. Conditional Pass is 80-89%. Not Pass is below 80%. The minimum passing score is 80%. A corrective action plan (CAP) is required for a total MRR score below 90%. Also, any section score of less than 80% requires a CAP for the entire MRR, regardless of the total MRR score. Not applicable ("N/A") applies to any criterion that does not apply to the medical record being reviewed, and must be explained in the comment section. Medical records shall be randomly selected using methodology decided upon by the reviewer. Ten (10) medical records are surveyed for each PCP, five (5) adult and/or obstetric records and five (5) pediatric records. For sites with *only* adult, *only* obstetric, or *only* pediatric patient populations, all ten records surveyed will be in *only* one preventive care service area. Sites where documentation of patient care by all PCPs on site occurs in universally shared medical records shall be reviewed as a "shared" medical record system. Scores calculated on shared medical records apply to each PCP sharing the records. A minimum of ten shared records shall be reviewed for 2-3 PCPs, twenty records for 4-6 PCPs, and thirty records for 7 or more PCPs. Survey criteria to be reviewed *only* by a R.N. or physician are labeled "**RN/MD Review only".**

Directions: Score one point if criterion is met. Score zero points if criterion is not met. Do not score partial points for any criterion. If 10 shared records are reviewed, score calculation shall be the same as for 10 records reviewed for a single PCP. If 20 records are reviewed, divide total points given by the "adjusted" total points possible. If 30 records are reviewed, divide total points given by the "adjusted" total points possible. Multiply by 100 to calculate percentage rate. Reviewers have the option to request additional records to review, but must calculate scores accordingly. Reviewers are expected to determine the most appropriate method(s) on each site to ascertain information needed to complete the survey.

Scoring Example:

Step 1: Add the points given in each section.	**Step 2**: Add points given for all six (6) sections. (Format points given) (Documentation points given) (Coordination/Continuity-of-care points given) (Pediatric Preventive points given) (Adult Preventive points given) + (OB/CPSP Preventive points given) **= (Total points given)**
Step 3: Subtract the "N/A" points from total points possible. (Total points possible) – (N/A points) = ("Adjusted" total points possible)	**Step 4**: Divide total points given by the "adjusted" points possible, then multiply by 100 to calculate percentage rate. Total points given / "Adjusted" total points possible Example: 267 / 305 = 0.875 X 100 = **88%**

Rationale: A well-organized medical record keeping system supports effective patient care, information confidentiality and quality review processes.

Criteria	I. Format Reviewer Guidelines
A. An individual medical record is established for each member.	Practitioners are able to readily identify each individual treated. A medical record is started upon the initial visit. "Family charts" are not acceptable.
B. Member identification is on each page.	Member identification includes first and last name, and/or a unique identifier established for use on clinical site. Electronically maintained records and printed records from electronic systems must contain member identification.
C. Individual personal biographical information is documented.	Personal biographical information includes date of birth, current address, home/work phone numbers, and name of parent(s) /legal guardian if member is a minor. If member refused to provide information, "refused" is documented in the medical record. Do not deduct points if member has refused to provide all personal information requested by the practitioner.
D. Emergency "contact" is identified.	The name and phone number of an "emergency contact" person is identified for all members. Listed emergency contacts may include a spouse, relative or friend, and must include at least one of the following: home, work, pager, cellular or message phone number. If the member is a minor, the primary (first) emergency contact person must be a parent or legal guardian and then other persons may be listed as additional emergency contacts. Adults and emancipated minors may list anyone of their choosing. If a member refuses to provide an emergency contact, "refused" is noted in the record. Do not deduct points if member has refused to provide personal information requested by the practitioner.
E. Medical records are consistently organized.	Contents and format of printed and/or electronic records within the practice site are uniformly organized.
F. Chart contents are securely fastened.	Printed chart contents are securely fastened, attached or bound to prevent medical record loss. Electronic medical record information is readily available.
G. Member's assigned primary care physician (PCP) is identified.	The assigned PCP is ***always*** identified when there is more than one PCP on site and/or when the member has selected health care from a non-physician medical practitioner. Since various methods are used to identify the assigned PCP, reviewers must identify specific method(s) used at each individual site such as Health Plan ID Card, practitioner stamp, etc.
H. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing-impaired persons are prominently noted.	The primary language and *requests* for language and/or interpretation services by a non-or limited-English proficient member are documented. Member refusal of interpreter services is documented. The PCP and/or appropriate clinic staff member who speak the member's language fluently can be considered a qualified interpreter. Family or friends should not be used as interpreters, unless specifically requested by the member. Language documentation is not necessary "N/A," if English is the primary language, however, if "English" *is documented*, the point may be given. **Note:** Title VI of the Civil Rights Act of 1964 prohibits recipients of federal funds from providing services to LEP persons that are limited in scope or lower in quality than those provided to others. Since Medi-Cal is partially funded by federal funds, ***all*** Plans with Medi-Cal LEP members must ensure that these members have equal access to all health care services (MMCD Policy Letter 99-03).

I. Format Criteria

Note: A Format section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. An individual medical record is established for each member.	**1**											
B. Member identification is on each page.	**1**											
C. Individual personal biographical information is documented.	**1**											
D. Emergency "contact" is identified.	**1**											
E. Medical records on site are consistently organized.	**1**											
F. Chart contents are securely fastened.	**1**											
G. Member's assigned primary care physician (PCP) is identified.	**1**											
H. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing-impaired persons are prominently noted.	**1**											
	Yes											
Comments:	No											
	N/A											
	8 **Pts. Possible**											

Rationale: Well-documented records facilitate communication and coordination, and promote efficiency and effectiveness of treatment. **RN/MD Review only**

Criteria	II. Documentation Reviewer Guidelines
A. Allergies are prominently noted.	Allergies and adverse reactions are listed in a prominent, easily identified and consistent location in the medical record. If member has no allergies or adverse reactions, "No Known Allergies" (NKA), "No known Drug Allergies" (NKDA), or ∅ is documented.
B. Chronic problems and/or significant conditions are listed.	Documentation may be on a separate "problem list," or a clearly identifiable problem list in the progress notes. All chronic or significant problems are considered current if no "end date" is documented. **Note:** Chronic conditions are current long-term, on-going conditions with slow or little progress.
C. Current *continuous* medications are listed.	Documentation may be on a separate "medication list," or a clearly identifiable medication list in the progress notes. List of current, on-going medications identifies the medication name, strength, dosage, route (if other than oral), and frequency. Discontinued medications are noted on the medication list or in progress notes.
D. Signed Informed Consents are present when any invasive procedure is performed.	Adults, parents/legal guardians of a minor or emancipated minors may sign consent forms for operative and invasive procedures.* Persons under 18 years of age are emancipated if they have entered into a valid marriage, are on military active duty, or have received a court declaration of emancipation under the CA Family Code, Section 7122. Note: Human sterilization requires DHCS Consent Form PM 330. * An invasive procedure is a medical procedure that invades (enters) the body, usually by cutting or puncturing the skin or by inserting instruments into the body. Very minor procedures such as drawing blood testing, umbilical cord blood donations and a few other very specific tests are not considered invasive and do not require a consent. Consent is implied by entering the provider's office or lab and allowing blood to be drawn. Ref: National Institutes of Health; American Cancer Society. Note: Written consent for HIV testing is no longer required (AB 682) 2007.
E. Advance Health Care Directive information is offered. (Adults 18 years or age or older; Emancipated minors)	Adult medical records include documentation of whether the member has been offered information or has executed an Advance Health Care Directive (California Probate Code, Sections 4701).
F. All entries are signed, dated and legible.	**Signature:** includes the first initial, last name and title of health care personnel providing care, including Medical Assistants. Initials may be used only if signatures are specifically identified elsewhere in the medical record (e.g. signature page). Stamped signatures are acceptable, but must be authenticated, meaning the stamped signature can be verified, validated, confirmed, and is countersigned or initialed. Note: In electronic records (EMR), methods to document signatures (and/or authenticate initials) will vary, and must be individually evaluated. Reviewers should assess the log-in process and may need to request print-outs of entries. **Date:** includes the month/day/year. Only standard abbreviations are used. Entries are in reasonably consecutive order by date. Handwritten documentation does not contain skipped lines or empty spaces where information can be added. Entries are not backdated or inserted into spaces above previous entries. Omissions are charted as a new entry. Late entries are explained in the medical record, signed and dated. **Legibility:** means the record entry is readable by a person other than the writer. Handwritten documentation, signatures and initials are entered in ink that can be readily/clearly copied.
G. Errors are corrected according to legal medical documentation standards.	The person that makes the documentation error corrects the error. One correction method is (single line drawn through the error, with the writer's initial and date written above or near the lined-through entry). Similar variations such as (single line and initial) are also used. The corrected information is written as a separate entry and includes date of the entry, signature (or initials), and title. There are no unexplained cross-outs, erased entries or use of correction fluid. Both the original entry and corrected entry are clearly preserved. Note: Reviewers must determine the method used for error corrections for EMR on a case by case basis. This should include the log-in process and whether the EMR allows for corrections to be made after entries are made.

II. Documentation Criteria

Note: A Documentation section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Allergies are prominently noted.	**1**											
B. Chronic problems and/or significant conditions are listed.	**1**											
C. Current *continuous* medications are listed.	**1**											
D. Signed Informed Consents are present when any invasive procedure is performed.	**1**											
E. Advance Health Care Directive information is offered. (Adults 18 years of age or older; Emancipated minors)	**1**											
F. All entries are signed, dated and legible.	**1**											
G. Errors are corrected according to legal medical documentation standards.	**1**											
	Yes											
	No											
	N/A											

Comments:

7
Pts. Possible

Rationale: Medical records support coordination and continuity-of-care with documentation of past and present health status, medical treatment and future plans of care.
RN/MD Review only

Criteria	III. Coordination/Continuity of Care Reviewer Guidelines
A. History of present illness is documented.	Each focused visit (e.g., primary care, urgent care, acute care, etc.) includes a documented history of present illness.
B. Working diagnoses are consistent with findings.	Each visit has a documented "working" diagnosis/impression derived from a physical exam, and/or "Subjective" information such as chief complaint or reason for the visit as stated by member/parent. The documented "Objective" information (such as assessment, findings and conclusion) relate to the working diagnoses. **Note:** For scoring purposes, reviewers shall ***not make determinations*** about the *"rightfulness or wrongfulness"* of documented information, but shall initiate the peer review process as appropriate.
C. Treatment plans are consistent with diagnoses.	A plan of treatment, care and/or education related to the stated diagnosis is documented for each diagnosis. **Note:** For scoring purposes, reviewers shall ***not make determinations*** about the *"rightfulness or wrongfulness"* of treatment rendered or care plan, but shall initiate the peer review process as appropriate.
D. Instruction for follow-up care is documented.	Specific follow-up instructions and a definite time for return visit or other follow-up care is documented. Time period for return visits or other follow-up care is definitively stated in number of days, weeks, months, or PRN (as needed).
E. Unresolved and/or continuing problems are addressed in subsequent visit(s).	Previous complaints and unresolved or chronic problems are addressed in subsequent notes until problems are resolved or a diagnosis is made. Each problem need not be addressed at every visit. Documentation demonstrates that the practitioner follows up with members about treatment regimens, recommendations, and counseling.
F. There is evidence of practitioner *review* of consult/referral reports and diagnostic test results.	There is documented evidence of practitioner review of records such as diagnostic studies, lab tests, X-ray reports, consultation summaries, inpatient/discharge records, emergency and urgent care reports, and all abnormal and/or "STAT" reports. Evidence of review may include the practitioner's initials or signature on the report, notation in the progress notes, or other site-specific method of documenting practitioner review. Note: Electronically maintained medical reports must also show evidence of practitioner review, and may differ from site to site.
G. There is evidence of *follow-up* of specialty referrals made, and results/reports of diagnostic tests, when appropriate.	Consultation reports and diagnostic test results are documented for ordered requests. Abnormal test results/diagnostic reports have explicit notation in the medical record, including attempts to contact the member/guardian, follow-up treatment, instructions, return office visits, referrals and/or other pertinent information. Missed/broken appointments for diagnostic procedures, lab tests, specialty appointments and/or other referrals are noted, and include attempts to contact the member/parent and results of follow-up actions.
H. Missed primary care appointments and outreach efforts/follow-up contacts are documented.	Documentation includes incidents of missed/broken appointments, cancellations or "No shows" with the PCP office. Attempts to contact the member or parent/guardian and the results of follow-up actions are documented.

III. Coordination/Continuity of Care Criteria

Note: A Coordination/Continuity section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. History of present illness is documented.	**1**											
B. Working diagnoses are consistent with findings.	**1**											
C. Treatment plans are consistent with diagnoses.	**1**											
D. Instruction for follow-up care is documented.	**1**											
E. Unresolved/continuing problems are addressed in subsequent visit(s).	**1**											
F. There is evidence of practitioner *review* of consult/referral reports and diagnostic test results.	**1**											
G. There is evidence of *follow-up* of specialty referrals made, and results/reports of diagnostic tests, when appropriate	**1**											
H. Missed primary care appointments and outreach efforts/follow-up contacts are documented.	**1**											
	Yes											
	No											
	N/A											

Comments:

8
Pts. Possible

Rationale: Pediatric preventive services are provided in accordance with current AAP periodicity, and include CHDP assessments. **RN/MD Review only**

Criteria	IV. Pediatric Preventive Reviewer Guidelines (continued on next page)
A. Initial Health Assessment (IHA) IHA includes H&P and IHEBA	The IHA (H&P and IHEBA) enables the PCP to assess current acute, chronic and preventive needs *and* to identify those Members whose health needs require coordinated services with appropriate community resources/other agencies not covered by the Plan.
1. History and physical (H&P)	**New members**: An H&P is completed within 120 days of the effective date of enrollment into the Plan, or documented within the 12 months prior to Plan enrollment. The H&P is sufficiently comprehensive to assess and diagnose acute and chronic conditions, which may include: history of present illness, past medical and social history, and review of organ systems. If an H&P is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented.
2. Individual Health Education Behavioral Assessment (IHEBA)	**New members**: An age-appropriate IHEBA ("Staying Healthy" or other DHCS-approved tool) is completed by the member or parent/guardian within 120 days of the effective date of enrollment into the Plan, or within the 12 months prior to Plan enrollment. Staff may assist. The IHEBA has evidence of practitioner review such as signature/initials, and dates and intervention codes, which may be documented on the IHEBA form, in progress notes, or other areas of the paper or electronic medical record system. If an initial IHEBA is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented.
B. Subsequent Periodic IHEBA	An age-appropriate IHEBA is re-administered when the member has reached the next specific age interval designated by MMCD. Documentation requirements are the same as the initial IHEBA.
C. Well-Child Visit	
1. Well-child exam completed at age appropriate frequency	Health assessments containing CHDP age-appropriate content requirements are provided according to the most recent AAP periodicity schedule for pediatric preventive health care. Assessments and identified problems recorded on the PM160 form are documented in the progress notes. Follow-up care or referral is provided for identified physical health problems as appropriate. **Note**: Where the AAP periodicity exam schedule is more frequent than the CHDP periodicity examination schedule, the AAP scheduled visit must include all assessment components required by the CHDP program for the lower age nearest to the current age of the child.
2. Anthropometric measurements	Height and weight are documented at each well-child exam. Include head circumference for infants up to 24 months.
3. BMI Percentile	BMI percentile is plotted on an appropriate CDC growth chart for each well-child exam ages 2-20 years. Note: The BMI percentile calculation is based on the CDC's BMI-for-age- growth charts, which indicates the relative position of the patient's BMI number among others of the same sex and age. Ref: www.cdc.gov/nccdphp/dnpa/bmi/index.htm
4. Developmental screening	Developmental surveillance at each visit and screening for developmental disorders at the 9th, 18th and 30th month visits. Children identified with potential delays require further assessment and/or referral. (Ref: AAP and CHDP periodicity schedules)
5. Anticipatory guidance	Includes age appropriate counseling/health education provided to parent or pediatric member.
6. STI screening on all sexually active adolescents, incl. chlamydia for females	All sexually active adolescents should be screened for sexually transmitted infections (STIs), including chlamydia for females.
7. Pap smear on sexually active females	Pap smear within 3 years of onset of sexual intercourse.
D. Vision Screening	Age-appropriate visual screening occurs at each health assessment visit, with referral to optometrist/ophthalmologist as appropriate. **Note:** Although specific screening details are not generally documented in the medical record, screening for infants and children (birth to 3 years) may consist of evaluations such as external eye inspection, ophthalmoscopic red reflex examination, or corneal penlight evaluation. Visual acuity screening usually begins at age 3 years.

IV. Pediatric Preventive Criteria (continued on next page)

Note: A Pediatric Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only Note:

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Initial Health Assessment (IHA) Includes H&P and IHEBA												
1. History and physical (H&P)	**1**											
2. Individual Health Education Behavioral Assessment (IHEBA)	**1**											
B. Subsequent Periodic IHEBA	**1**											
C. Well-child visit												
1. Well-child exam completed at age appropriate frequency	**1**											
2. Anthropometric measurements	**1**											
3. BMI percentile	**1**											
4. Developmental screening	**1**											
5. Anticipatory guidance	**1**											
6. STI screening on all sexually active adolescents, including chlamydia for females	**1**											
7. Pap smear on sexually active females	**1**											
D. Vision Screening	**1**											

Pediatric Preventive continued on next page

Criteria	IV. Pediatric Preventive Reviewer Guidelines RN/MD Review only (continued from previous page)
E. Hearing Screening	Non-audiometric screening for infants/children (2 months to 3 years) includes family and medical history, physical exam and age-appropriate screening. Audiometric screening for children and young adults (3 -20) is done at each health assessment visit and includes follow-up care as appropriate. A failed audiometric screening is followed up with a repeat screening at least two weeks and no later than 6 weeks after the initial screening. If the second screening also fails, there is a referral to a specialist.
F. Nutrition Assessment	Screening includes: 1) height and weight, 2) hematocrit or hemoglobin to screen for anemia starting at 9-12 months, and 3) breastfeeding and infant feeding status, food/nutrient intake and eating habits (including evaluation of problems/conditions/needs of the breastfeeding mother). Based on problems/conditions identified, nutritionally at-risk children under 5 years of age are referred to the Women, Infants and Children (WIC) Supplemental Nutrition Program for medical nutrition therapy or other in-depth nutritional assessment.
G. Dental Assessment	Inspection of the mouth, teeth and gums is performed at every health assessment visit. Children are referred to a dentist ***at any age*** if a dental problem is detected or suspected. Beginning at 3 years of age, all children are referred annually to a dentist regardless of whether a dental problem is detected or suspected.
H. Blood Lead Screening Test	Children receiving health services through Medi-Cal Managed Care Plans must have blood lead level (BLL) testing as follows: 1) at 12 month *and* 24 months of age, 2) between 12 months and 24 months of age *if* there is no documented evidence of BLL testing at 12 months or thereafter, *and* 3) between 24 months and 72 months of age *if* there is no documented evidence of BLL testing at 24 months or thereafter. Elevated BLL of 10 µg/dL or greater require additional BLL and follow-up in accordance with current DHCS policy or as follows: • 10-14 µg/dL: Confirm with venous sample within 3 months of original test; • 15-19 µg/dL: Confirm with venous sample within 2 months of original test, then retest 2 months following the confirmatory testing; • 20-44 µg/dL: Confirm with venous sample in 1 week to 1 month, depending on severity of BLL; • 45-59 µg/dL: Retest with venous sample within 48 hour; • 60-69 µg/dL: Retest with venous sample within 24 hours; • ≥ 70 µg/dL: EMERGENCY. Retest immediately with venous sample. Children with elevated BLLs are referred to the local Childhood Lead Poisoning Prevention Branch or, if none, to the local health department. All children with confirmed (venous) BLLs of ≥ 20 µg/dL must be referred to CCS.
I. Tuberculosis Screening	All children are assessed for risk of exposure to tuberculosis (TB) at each health assessment. The Mantoux skin test, or other approved TB infection screening test,* is administered to children *identified at risk*, if there has not been a test in the previous year. The Mantoux is not given if a previously positive Mantoux is documented. Documentation of a positive test includes follow-up care (e.g. further medical evaluation, chest x-ray, diagnostic laboratory studies and/or referral to specialist). Practitioners are required to follow current CDC and American Thoracic Society guidelines for TB diagnosis and treatment. *Per June 25, 2010 CDC MMWR, FDA approved IGRA serum TB tests, i.e., QuantiFERON®-TB Gold (QFT-G and QFT-GIT) and T-SPOT®.TB (T-Spot). The Mantoux is preferred over IGRA for children under 5 years of age. Ref: www.cdc.gov/tb/publications/factsheets/testingIGRA.htm
J. Childhood Immunizations	
1. Given according to ACIP guidelines	Immunization status is assessed at each health assessment visit. Practitioners are required to ensure the provision of immunizations according to CDC's most recent Advisory Committee on Immunization Practices (ACIP) guidelines, unless medically contraindicated or refused by the parent.
2. Vaccine administration documentation	The name, manufacturer, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries.
3. Vaccine Information Statement (VIS) documentation	The date the VIS was given (or presented and offered) *and* the VIS publication date are documented in the medical record.

IV. Pediatric Preventive Criteria (continued from previous page)

Note: A Pediatric Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
E. Hearing Screening	**1**											
F. Nutrition Assessment	**1**											
G. Dental Assessment	**1**											
H. Blood Lead Screening Test	**1**											
I. Tuberculosis Screening	**1**											
J. Childhood Immunizations												
1. Given according to ACIP guidelines	**1**											
2. Vaccine administration documentation	**1**											
3. Vaccine Information Statement (VIS) documentation	**1**											
	Yes											
Comments:	No											
	N/A											

19
Pts. Possible

Rationale: Current Guide to Clinical Preventive Services, U.S. Preventive Services Task Force (USPSTF) Report is the minimum standard for adult preventive health services. **RN/MD Review only**

Criteria	V. Adult Preventive Reviewer Guidelines (continued on next page)
A. Initial Health Assessment (IHA) Includes H&P and IHEBA	The IHA (H&P and IHEBA) enables the PCP to assess current acute, chronic and preventive needs *and* identify those Members whose health needs require coordinated services with appropriate community resources/other agencies not covered by the Plan.
1. History and physical (H&P)	**New members**: An H&P is completed within 120 days of the effective date of enrollment into the Plan, or documented within the 12 months prior to Plan enrollment. The H&P is sufficiently comprehensive to assess and diagnose acute and chronic conditions, which may include: history of present illness, past medical and social history, and review of organ systems. If an H&P is not found in the medical record, the reasons (e.g., member's refusal, missed appointment) and contact attempts to reschedule are documented.
2. Individual Health Education Behavioral Assessment (IHEBA)	**New members**: An age-appropriate IHEBA ("Staying Healthy" or other DHCS-approved tool) is completed by the member within 120 days of the effective date of enrollment into the Plan, or within the 12 months prior to Plan enrollment. Staff may assist. The IHEBA has evidence of practitioner review such as signature/initials, and dates and intervention codes, which may be documented on the IHEBA form, in progress notes, or other areas of the paper or electronic medical record system. If an initial IHEBA is not found in the medical record, the reasons (e.g., member's refusal, missed appointment) and contact attempts to reschedule are documented.
B. Subsequent Periodic IHEBA	An age-appropriate IHEBA is re-administered when the member has reached the next specific age interval designated by MMCD. Documentation requirements are the same as the initial IHEBA.
C. Periodic Health Evaluation according to most recent USPSTF Guidelines.	Periodic health evaluations occur in accordance with the frequency that is appropriate for individual risk factors. The type, quantity and frequency of preventive services will depend on the most recent USPSTF recommendations. In addition to USPSTF recommendations, periodic health evaluations are scheduled as indicated by the member's needs and according to the clinical judgment of the practitioner. Example: A patient with elevated cholesterol levels and other risk factors for coronary heart disease (CHD) may be evaluated more frequently than other persons of the same age without similar risk factors.
D. High Blood Pressure Screening	All adults 18 years and older including those without known hypertension are screened. A blood pressure (B/P) measurement for the normotensive adult is documented at least once every 2 years if the last systolic reading was below 120 mmHg and the diastolic reading was below 80 mmHg. B/P is measured annually if the last systolic reading was 120 to 139 mmHg and the diastolic reading was 80 to 89 mmHg. USPSTF link for high blood pressure screening: http://www.uspreventiveservicestaskforce.org/uspstf07/hbp/hbprs.htm
E. Obesity Screening	Includes weight and body mass index (BMI).
F. Lipid Disorders Screening	All men (ages 35 years and older) are screened. Women (ages 45 years and older) are screened if at increased risk for coronary heart disease. Screening includes measurement of total cholesterol (TC) and high-density lipoprotein cholesterol (HDL-C). **Note:** Men under 35 years and women under 45 year may also be screened for lipid disorders if at increased risk for coronary artery disease. USPSTF link for lipid disorder screening: http://www.uspreventiveservicestaskforce.org/uspstf/uspschol.htm

V. Adult Preventive Criteria (continued on next page)

Note: An Adult Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Initial Health Assessment (IHA): Includes H&P and IHEBA												
1. History and physical (H&P)	**1**											
2. Individual Health Education Behavioral Assessment (IHEBA)	**1**											
B. Subsequent Periodic IHEBA	**1**											
C. Periodic Health Evaluation according to most recent USPSTF Guidelines	**1**											
D. High Blood Pressure Screening	**1**											
E. Obesity Screening	**1**											
F. Lipid Disorders Screening	**1**											

Adult Preventive continued on next page

Criteria	V. Adult Preventive Reviewer Guidelines (continued from previous page)
G. Tuberculosis Screening	Adults are screened for tuberculosis (TB) risk factors upon enrollment and at periodic physical evaluations. The Mantoux skin test, or other approved TB infection screening test,* is administered to **all** asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they had not had a test in the previous year. Adults already known to have HIV or who are significantly immunosuppressed require annual TB testing.** The Mantoux is not given if a previously positive Mantoux is documented. Documentation of a positive test includes follow-up care (e.g. further medical evaluation, chest x-ray, diagnostic laboratory studies and/or referral to specialist). Practitioners are required to follow current CDC and American Thoracic Society guidelines for TB diagnosis and .treatment. * Per June 25, 2010 CDC MMWR, the FDA approved IGRA serum TB tests, such as QuantiFERON®-TB Gold (QFT-G and QFT-GIT) and T-SPOT®.TB (T-Spot). Ref: www.cdc.gov/tb/publications/factsheets/testingIGRA.htm ** Per CTCA/CDPH: http://www.ctca.org/guidelines/IIA2targetedskintesting.pdfwww.ctca.org/guidelines/IIA2targetedskintesting.pdf
H. Breast Cancer Screening	A routine screening mammography for breast cancer is completed every 1-2 years on all women starting at age 50, concluding at age 75 unless pathology has been demonstrated. USPSTF link: http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca.htm
I. Cervical Cancer Screening	Routine screening for cervical cancer with Papanicolaou (Pap) testing is done on all women who are or have been sexually active and who have a cervix. Pap smears should begin within 3 years of onset of sexual activity or age 21 (whichever comes first) and repeated at least every 1-3 years depending on individual risk factors. Follow-up of abnormal test results is documented. According to the USPSTF, routine Pap testing may not be required for the following: 1) women who have undergone hysterectomy in which the cervix is removed, unless the hysterectomy was performed because of invasive cancer, 2) women after age 65 who have had regular previous screening in which the smears have been consistently normal. USPSTF link for cervical cancer screening: http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm
J. Chlamydia Infection Screening	Women who are sexually active are screened from the time they become sexually active until they are 25 years of age. Practitioner may screen women older than 25 years of age if the practitioner determines that the patient is at risk for infection. Lab results are documented.
K. Colorectal Cancer Screening	All adults are screened for colorectal cancer beginning at age 50 years and continuing until age 75 years to include: 1. Annual screening with high-sensitivity fecal occult blood testing, **or** 2. Sigmoidoscopy every 5 years with high sensitivity fecal occult blood testing every 3 years, **or** 3. Screening colonoscopy every 10 years. USPSTF link for colorectal cancer screening: http://www.uspreventiveservicestaskforce.org/uspstf/uspscolo.htm
L. Adult Immunizations	
1. Given according to ACIP guidelines	Immunization status is assessed at periodic health evaluations. Practitioners are required to ensure the provision of immunizations according to CDC's most recent Advisory Committee on Immunization Practices (ACIP) guidelines, unless medically contraindicated or refused by the member.
2. Vaccine administration documentation	The name, manufacturer, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries.
3. Vaccine Information Statement (VIS) documentation	The date the VIS was given (or presented and offered) *and* the VIS publication date are documented in the medical record.

V. Adult Preventive Criteria (continued from previous page)

Note: An Adult Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
G. Tuberculosis Screening	**1**											
H. Breast Cancer Screening	**1**											
I. Cervical Cancer Screening	**1**											
J. Chlamydia Infection Screening	**1**											
K. Colorectal Cancer Screening	**1**											
L. Adult Immunizations												
1. Given according to ACIP guidelines	**1**											
2. Vaccine administration documentation	**1**											
3. Vaccine Information Statement (VIS) documentation	**1**											
	Yes											
	No											
	N/A											

Comments:

15
Pts. Possible

Rationale: Perinatal assessments are provided according to the current American College of Obstetrics and Gynecologists (ACOG) standards and Comprehensive Perinatal Services Program (CPSP) Guidelines. **RN/MD Review only**

Criteria	VI. OB/CPSP Preventive Reviewer Guidelines (continued on next page)
A. Initial Comprehensive Assessment (ICA)	**Note: Item A.1 assesses the timeframe of a completed ICA. Items A2-9 assess the individual components of the ICA, and can receive a "yes" score - *apart from the timeframe*.**
1. ICA completed within 4 weeks of entry to prenatal care	The ICA was completed within 4 weeks of entry to prenatal care.
2. Obstetrical and Medical History	Obstetric/medical: Health and obstetrical history (past/current), LMP, EDD.
3. Physical Exam	Physical exam: includes breast and pelvic exam.
4. Lab tests	Lab tests: hemoglobin/hematocrit, urinalysis, urine culture, ABO blood group, Rh type, rubella antibody titer, STI screen.
5. Nutrition	Nutrition: Anthropometric (height/weight), dietary evaluation, prenatal vitamin/mineral supplementation.
6. Psychosocial	Psychosocial: Social and mental health history (past/current), substance use/abuse, support systems/resources.
7. Health Education	Health education: Language and education needs.
8. Screening for Hepatitis B Virus	All pregnant women are screened for Hepatitis B during their first trimester or prenatal visit, whichever comes first.
9. Screening for Chlamydia Infection	All pregnant women ages 25 and younger, and older pregnant women who are at increased risk, are screened for chlamydia during their first prenatal visit.
B. Second Trimester Comprehensive Re-assessment	Subsequent comprehensive prenatal re-assessments include Obstetric/medical, Nutrition, Psychosocial and Health Education re-assessments are completed during the 2nd trimester.
C. Third Trimester Comprehensive Re-assessment	Subsequent comprehensive prenatal re-assessments include Obstetric/medical, Nutrition, Psychosocial and Health Education re-assessments are completed during the 3rd trimester.
1. Screening for Strep B	All pregnant women are screened for Group B Streptococcus between their 35th and 37th week of pregnancy.
D. Prenatal care visit periodicity according to most recent ACOG standards	ACOG's *Guidelines for Perinatal Care* recommend the following prenatal schedule for a 40-week uncomplicated pregnancy: • First visit by 6-8th week • Approximately every 4 weeks for the first 28 weeks of pregnancy • Every 2-3 weeks until 36 weeks gestation • Weekly thereafter until delivery • Postpartum visit within 4-8 weeks after delivery If the recommended ACOG schedule is not met, documentation shows missed appointments, attempts to contact member and/or outreach activities.

VI. OB/CPSP Preventive Criteria (continued on next page)

Note: An OB/CPSP Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Initial Comprehensive Prenatal Assessment (ICA)												
1. ICA completed within 4 weeks of entry to prenatal care	1											
2. Obstetrical and Medical History	1											
3. Physical Exam	1											
4. Lab tests	1											
5. Nutrition	1											
6. Psychosocial	1											
7. Health Education	1											
8. Screening for Hepatitis B Virus	1											
9. Screening for Chlamydia Infection	1											
B. Second Trimester Comprehensive Re-assessment	1											
C. Third Trimester Comprehensive Re-assessment	1											
1. Screening for Strep B	1											
D. Prenatal care visit periodicity according to most recent ACOG standards	1											

OB/CPSP continued on next page

Rationale: Perinatal assessments are provided according to the current American College of Obstetrics and Gynecologists (ACOG) standards and Comprehensive Perinatal Services Program (CPSP) Guidelines. **RN/MD Review only**

Criteria	VI. OB/CPSP Preventive Reviewer Guidelines (continued from previous page)
E. Individualized Care Plan (ICP)	ICP documentation includes specific obstetric, nutrition, psychosocial and health education risk problems/conditions, interventions, and referrals.
F. Referral to WIC and assessment of Infant Feeding status	Pregnant and breastfeeding Plan members must be referred to WIC (Public Law 103-448, Section 203(e)). Referral to WIC is documented in the medical record (Title 42, CFR 431.635). Infant feeding plans are documented during the prenatal period, and infant feeding/breastfeeding status is documented during the postpartum period (MMCD Policy Letter 98-10). **Note:** Although WIC determines eligibility for program participation, nearly all Medi-Cal beneficiaries are income eligible for WIC. Federal regulations specify that pregnant and breastfeeding women are given the highest priority for WIC Program enrollment.
G. HIV-related services *offered*	The ***offering*** of prenatal HIV information, counseling and HIV antibody testing is documented (CA Health & Safety Code, Section 125107). Practitioners are ***not required*** to document that the HIV test was given or disclose (except to the member) the results (positive or negative) of an HIV test. Offering a prenatal HIV test is not required if a positive HIV test is already documented in the patient's record or if the patient has AIDS diagnosed by a physician. **Note:** Member's participation is voluntary. Practitioner may provide HIV test or refer to other testing program/site. Documentation or disclosure of HIV related information must be in accordance with confidentiality and informed consent regulations.
H. AFP/Genetic Screening *offered*	The ***offering*** of blood screening tests prior to 20 weeks gestation counting from the first day of the last normal menstrual period is documented (CCR, Title 17, Sections 6521-6532). Genetic screening documentation includes: 1) family history, 2) Triple marker screening tests: Alpha Fetoprotein (AF), unconjugated estriol (UE), human chorionic gonadotropin (HCG), 3) member's consent or refusal to participate. **Note:** Member's participation is voluntary. Testing occurs through CDPH Expanded AFP Program, and only laboratories designated by CDPH may be used for testing.
I. Domestic Violence/Abuse Screening	Provision of a Domestic Violence Screening is documented. Assessment checklists, body diagrams and/or documentation in progress notes are acceptable. Domestic violence screening includes medical screening, documentation of physical injuries or illnesses attributable to spousal/partner abuse, and referral to appropriate community service agencies (CA Health & Safety Code, Section 1233.5).
J. Family Planning Evaluation	Family Planning counseling, referral or provision of services is documented (MMCD Policy Letter 98-11).
K. Postpartum Comprehensive Assessment	Comprehensive postpartum reassessment includes the 4 components: medical exam, nutrition (mother and infant), psychosocial, health education are completed within 4-8 weeks postpartum (MMCD Policy Letter 96-01). If the postpartum assessment visit is not documented, medical record documents missed appointments, attempts to contact member and/or outreach activities. Infant feeding/breastfeeding status is documented during the postpartum period (MMCD Policy Letter 98-10).

VI. OB/CPSP Preventive Criteria (continued from previous page)

Note: An OB/CPSP Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
E. Individualized Care Plan (ICP)	**1**											
F. Referral to WIC and assessment of Infant Feeding status	**1**											
G. HIV-related services *offered*	**1**											
H. AFP/Genetic screening *offered*	**1**											
I. Domestic Violence/Abuse Screening	**1**											
J. Family Planning Evaluation	**1**											
K. Postpartum Comprehensive Assessment	**1**											
	Yes											
	No											
	N/A											

Comments:

20
Pts. Possible

MEDI-CAL COLLABORATIVE HEALTH PLANS
POST SITE REVIEW SATISFACTION SURVEY

To continually enhance the Health Plan Facility and Medical Record review process we would appreciate your responses on the survey below. Please mark those responses that best indicate your level of satisfaction with today's facility and/or medical record review. Confidentiality of this survey will be maintained; only the aggregate report will be provided to the health plan and involved associates. Please return this survey by fax or mail to:

Blue Shield of California Promise Health Plan
Krista Riganti, RN, DHCS-MT, Sr. Manager of Quality Improvement
601 Potrero Grande Drive
Monterey Park, CA 91755
Phone: (323) 827-6147
FAX: (323) 888-0968

Date: **DHCS ID:**

County/LOB	Reviewer	Review Type
☐ Los Angeles 100,120,2400 ☐ San Diego 700,720,2400	☐ Krista Riganti, RN, DHCS-MT ☐ Angela P. Ubiadas, RN, DHCS-MT ☐ Marlyn Enguerra, RN, DHCS-CSR ☐ Lady M. Chang, RN, DHCS-CSR ☐ Jennifer Chobaz, RN, DHCS-CSR ☐ Angel Perlas, RN, DHCS-CSR ☐ Charmaine Bucton, RN, DHCS-CSR ☐ Ruben Diaz ☐ Erick Enriquez ☐ Moises Ayala	☐ Facility Site Review ☐ Medical Record Review ☐ Physical Accessibility Review Survey

Please indicate (X) your level of agreement with the following statements	Strongly Agree	Agree	Somewhat Agree	Disagree	Strongly Disagree
The Auditor					
The reviewer arrived on time					
The reviewer was courteous					
The reviewer was able to answer questions					
The reviewer asked for your input to ensure review responses were accurate					
The Audit					
Our office received information explaining what to expect and what the office needed to prepare for the review					
The review was conducted efficiently					
During the review exit conference, the reviewer and I discussed the review results and corrective action requirements with the designated staff and/or Physician.					
The Process:					
Our Office was provided sufficient information to complete the corrective actions.					
The facility review process has been improved by the Health Plan collaboration.					

Comments: _____

_____

_____

_____

Provider Name (optional): _____ Please contact me ☐

PCP SITE IDENTIFICATION FORM

Facility Name:			**DHCS Site ID#:**
Address:			
Site Email Address:			
IPA Name(s) for Medi-Cal Managed Care & Cal MediConnect (CMC) Programs:			
Telephone:		**Fax:**	
Office/Business Hours:	Monday	Tuesday	Wednesday
Thursday	Friday	Saturday	Sunday
Site Contact Person:		**Contact Person Email Address:**	
Contact Person Phone #:		**Review Date:**	**Time:**

Contracted Plan Partners: ☐ Anthem Blue Cross ☐ Blue Shield Promise Health Plan ☐ CareMore Health ☐ Health Net ☐ L.A. Care ☐ Molina

PHYSICIAN PROVIDER INFORMATION (please list additional providers on a separate form)

Name	License #	PCP and/or Specialty Type	Specific Days and Hours at this Site	Hospital Privileges Yes	No	Hospital
		Board Cert? ☐ Yes ☐ No				
		Board Cert? ☐ Yes ☐ No				
		Board Cert? ☐ Yes ☐ No				
		Board Cert? ☐ Yes ☐ No				
		Board Cert? ☐ Yes ☐ No				
		Board Cert? ☐ Yes ☐ No				
		Board Cert? ☐ Yes ☐ No				
		Board Cert? ☐ Yes ☐ No				

NON-PHYSICIAN (NP, PA, CNM) PROVIDER INFORMATION (please list additional providers on a separate form)

Name	Provider Type	License #	Supervising Physician/License:	Specific Days and Hours at this Site

OTHER BACK OFFICE STAFF:
# of RNs _____ # of LVNs _____ # of MAs _____ # of Other: _____
Title(s) of Other Staff: _____

LANGUAGE CAPABILITIES: List the language skills of on-site staff in addition to English

Physician(s) _____

Other staff _____

AGE OF POPULATION CARED FOR: AGES _____ TO _____

Percentage of population below 21 years of age: _____%

PLEASE READ CAREFULLY BEFORE SIGNING

SHARED PRACTICE ATTESTATION

The Department of Health Care Services (DHCS) Policy Letter 14-004 defines the documentation of patient care by all Primary Care Physicians (PCP) on site that occurs in universally shared medical records as a "shared" medical record practice. A shared medical record practice occurs when multiple PCPs see the same patients and use the same medical records for documentation of patient care. Shared medical records are not identified as separate records belonging to any specific PCP. Medical record review scores calculated on shared medical records apply to each PCP listed on the previous page.

Is this site a shared medical record practice? □ Yes □ No
Are there aspects of the medical record practice that is not shared by all PCPs on site (i.e. provider specialties, member age restrictions with certain PCPs, etc.)? □ Yes □ No □ N/A (please comment below)
Comments: _____
_____
_____

The collaborating Medi-Cal Managed Care and CMC Health Plans define the mutual and routine use of site personnel, office policies & procedures, facilities, equipment and other aspects of the clinic to complete daily activities and patient care in this physical address location as a "shared" site practice. Facility site review scores calculated on a shared site practice apply to each PCP listed on the previous page.

Is this a shared site practice? □ Yes □ No
Are there aspects of the site that is not shared by all PCPs on site (i.e. equipment, exam rooms, personnel, etc.)? □ Yes □ No □ N/A (please comment below)
Comments: _____
_____
_____

I hereby certify, under the penalty of perjury, that all statements made on this form are true and complete:

Provider/Designee Name (please print): _____ Job Title: _____

Signature: _____ Date: _____

FACILITY SITE REVIEW NOTIFICATION REQUEST: If Facility Site Review scores need to be forwarded to an additional person, please provide the following information:

Name/Title: _____

Name of Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

VERIFICATION OF REVIEWER'S TIME:

Time In: _____ Time Out: _____ Initials of above signer: _____

Reviewer's Signature _____

PCP SITE IDENTIFICATION FORM

Facility Name:			**DHCS Site ID#:**
Address:			
Site Email Address:			
IPA Name(s) for Medi-Cal Managed Care & Cal MediConnect (CMC) Programs:			
Telephone:		**Fax:**	
Office/Business Hours:	Monday	Tuesday	Wednesday
Thursday	Friday	Saturday	Sunday
Site Contact Person:		**Contact Person Email Address:**	
Contact Person Phone #:		**Review Date:**	**Time:**

Contracted Plan Partners: ☐ Aetna ☐ Blue Shield Promise Health Plan ☐UnitedHealthcare

☐ Health Net ☐ Community Health Group ☐ Molina

PHYSICIAN PROVIDER INFORMATION (please list additional providers on a separate form)

Name	License #	PCP and/or Specialty Type	Specific Days and Hours at this Site	Hospital Privileges Yes	No	Hospital
		Board Cert? ☐ Yes ☐ No				
		Board Cert? ☐ Yes ☐ No				
		Board Cert? ☐ Yes ☐ No				
		Board Cert? ☐ Yes ☐ No				
		Board Cert? ☐ Yes ☐ No				
		Board Cert? ☐ Yes ☐ No				
		Board Cert? ☐ Yes ☐ No				
		Board Cert? ☐ Yes ☐ No				

NON-PHYSICIAN (NP, PA, CNM) PROVIDER INFORMATION (please list additional providers on a separate form)

Name	Provider Type	License #	Supervising Physician/License:	Specific Days and Hours at this Site

OTHER BACK OFFICE STAFF:
# of RNs _____ # of LVNs _____ # of MAs _____ # of Other: _____
Title(s) of Other Staff: _____

LANGUAGE CAPABILITIES: List the language skills of on-site staff in addition to English

Physician(s) _____

Other staff _____

AGE OF POPULATION CARED FOR: AGES _____ TO _____

Percentage of population below 21 years of age: _____%

PLEASE READ CAREFULLY BEFORE SIGNING

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Comments: _____
_____
_____

The collaborating Medi-Cal Managed Care and CMC Health Plans define the mutual and routine use of site personnel, office policies & procedures, facilities, equipment and other aspects of the clinic to complete daily activities and patient care in this physical address location as a "shared" site practice. Facility site review scores calculated on a shared site practice apply to each PCP listed on the previous page.

Is this a shared site practice? □ Yes □ No
Are there aspects of the site that is not shared by all PCPs on site (i.e. equipment, exam rooms, personnel, etc.)? □ Yes □ No □ N/A (please comment below)
Comments: _____
_____
_____

I hereby certify, under the penalty of perjury, that all statements made on this form are true and complete:

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Signature: _____ Date: _____

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Name/Title: _____

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Address: _____

City: _____ State: _____ Zip Code: _____

VERIFICATION OF REVIEWER'S TIME:

Time In: _____ Time Out: _____ Initials of above signer: _____

Reviewer's Signature _____

Section: Access/Safety	
POLICY AND PROCEDURE: Site Accessibility by individuals with Physical Disabilities	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:_____

POLICY:
Site shall be accessible and useable by individuals with physical disabilities. The site will meet city, county and state building structure and access ordinances for persons with physical disabilities.

PROCEDURE:

I. ACCOMMODATIONS

A. The site shall maintain the following safety accommodations for physically disabled persons.
   1. Designated disabled parking space near the primary entrance.
      a. Staff will assist disabled members who choose to continue to seek care at the site, in spite of inaccessibility.
      b. Staff will discuss the plan with the member prior to a scheduled appointment. A meeting point, as near as possible to an entrance, will be agreed upon.
      c. Staff will meet the member at the scheduled time/place, and assist the member as appropriate.
   2. Pedestrian ramps will be maintained. (Any path is considered a ramp if the slope is greater than a one foot rise in twenty feet of horizontal run.)
      a. Level landings at the top and bottom of all ramps will be maintained clear of any obstruction. Every staff member is responsible for clearing the landings at any time an obstruction is noted.
   3. Exit doorways width (at least 32 inches) will allow for the passage of a wheelchair.
      a. Landings on each side of exit doors and the doorway openings will be maintained clear of any obstruction. Every staff member is responsible for clearing the landings and doorways at any time an obstruction is noted.
   4. Passenger elevator will be maintained in working condition for multi-level floor accommodation.
   5. A clear floor space will be provided for persons in wheelchairs.
   a. Staff may take the member into the exam room, or make adjustments in furniture as required.
   6. The restrooms will be accessible to physically disabled individuals

a. Staff may make a reasonable alternative available to the member, as needed. Alternative may include: direct or accompanying the member to a nearby disabled-accessible restroom, physically assisting the member into a smaller restroom, providing a urinal, bedpan or commode and sanitary supplies as acceptable to the member.

7. Hand washing facilities will be available and include running water, soap and paper towels.

a. Staff may provide a hand sanitizer to the member if the above items are not available/accessible.

8. Interpreter services for the hearing impaired will be provided as needed at no cost to the member.

9. Health education materials are made available to the members in alternative formats; providers can obtain these materials from their contracted health plans Health Education Departments.

II. CHANGES IN ACCESS/AVAILABILITY

A. Notification

1. If at any time the site becomes inaccessible to physically disabled individuals, all contracted health plans will be notified in writing.

POLICY:
Site environment will be maintained in a clean and sanitary condition. Environmental safety includes the hygienic condition of the site.

PROCEDURE:

I. GENERAL APPEARANCE

A. Patient areas, restrooms, furniture, walls, floors and carpets will be unsoiled, neat, tidy, uncluttered and in good repair.
   1. Cleaning will be performed regularly, as scheduled, by staff or contracted service. Office cleaning schedule is maintained as evidence of completion (see attachment sample).
   2. Staff are responsible to keep work areas neat and clean.
   3. Staff are responsible for reporting to the office manager/provider if any equipment, furniture, carpet, etc. is in need of repair. Office manager/provider will arrange for repair or replacement as needed.
   4. Staff are responsible to report to the office manager/provider any soiled carpet, walls, etc. that would require professional cleaning, repair or replacement. Office manager/provider will arrange for services.

II. SANITARY SUPPLIES

A. Appropriate sanitary supplies will be available for restroom use, including toilet tissue, hand washing soap, cloth/paper towels or antiseptic towelettes.
B. Staff will check restrooms frequently for presence of supplies and replenish supplies as necessary.

OFFICE CLEANING SCHEDULE

- Facility Cleaning

Occurs Daily By:	
Occurs Weekly By:	
Solution Used:	
Includes:	Floors
	Exam Tables
	Restrooms
	Furniture
	Dust Entire Office

- Exam room / Patient Restroom (if in Office) Daily Cleaning:

Solution Used:	
End Of Day By:	
As needed During day By:	

Biohazardous Spill during Office Hours

Assigned Person: _____

Uses only the Personnel Protection Kit (Spill or Infection control Kit)
Places materials in Red Biohazard bag and places in the Biohazard storage container.

Medical Office Cleaning Schedule

Cleaning and Decontamination of Equipment/Work Surfaces

Procedure:

1. All work surfaces and equipment must be cleaned with a 10% bleach solution (1:10 solution of household bleach and water) or other EPA registered solution. NOTE: Bleach must be EPA approved and hypochlorite content is at least 6.15% or higher.
2. 10% bleach solution must be changed/reconstituted every 24 hours and the date changed noted on the solution bottle.
3. Other disinfectant solution used for cleaning must be approved by the EPA (Environmental Protection Agency), effective in killing HIV/HBV/TB, and used according to the product label for the desired effect.
4. Clean work surfaces and/or equipment before and after each patient use and also on a daily basis.

Directions: Staff cleaning work surfaces and equipment must initial the appropriate box (month and day). Staff must initial and sign the bottom of this form to identify the name of the staff member.

LOCATION/AREA CLEANED: _____ Year: _____

	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
1												
2												
3												
4												
5												
6												
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31												

Staff Initials/ Signatures:

Print Staff Name: _____ Staff Signature: _____Initials: _____

Print Staff Name: _____ Staff Signature: _____ Initials: _____

Print Staff Name: _____ Staff Signature: _____ Initials: _____

Section: Access Safety	
POLICY AND PROCEDURE: Fire Safety and Prevention and Emergency Non-Medical Procedures	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:_____

POLICY:

Site shall be maintained in a manner that provides a safe environment for all patients, visitors and personnel. Site shall meet all city, county and state fire safety and prevention ordinances. Site staff shall receive training and information on fire safety & prevention and emergency non-medical procedures.

PROCEDURE:

I. SAFE ENVIRONMENT

A. The provider/designee will ensure the following fire and safety precautions:
   1. Lighting is adequate in all areas.
   2. Exit doors and aisles are unobstructed and egress (escape) Accessible
   3. Exit doors are clearly marked with "Exit" signs.
   4. Clearly diagramed "Evacuation Routes" for emergencies are posted in visible locations.
   5. Electrical cords and outlets are in good working condition.
   6. At least one type of fire fighting/protection equipment is accessible at all times.

B. Staff will be responsible to correct any "unsafe" situation, and/or report the situation to the provider/designee who will make/arrange for correction.

II. INFORMATION AND TRAINING

A. Fire Safety & Prevention and non-medical emergency information will be available on site. Staff will be informed of the location of the information and how to use the information. Staff training on fire safety & prevention and emergency non-medical procedures will be verifiable and may be part of staff education documented in:
   - Informal or formal in services
   - New staff orientation
   - External training courses

B. Training topics will include:
   1. Fire safety and prevention procedures including

a. evacuation routes and exits for the exam rooms, office suite and building.
b. Evacuation procedures.
c. Location of fire alarms, extinguishers, sprinklers and smoke detectors.
d. Emergency phone numbers.
e. Work place violence procedures including emergency numbers.

ATTACHMENTS: Workplace Violence Protocol (Resource)
Emergency Earthquake Plan (Resource)
Emergency Fire Plan (Resource)
Site Evacuation Plan (Sample)

Workplace Violence Protocol

I. Any staff member involved in an exchange with a patient or other visitor, which he/she perceives to be escalating will:

a. ask the visitor to remain calm. If the discussion continues to escalate he/she will notify the supervisor/practitioner.

b. ensure the safety of staff, patients and visitors.

c. if alone in the office, ask the visitor to leave.

d. if the situation continues to escalate, the visitor does not leave, or at any time the staff member feels threatened, **Dial 911** to summon police.

II. Any staff member who witnesses violence in the office will:

a. immediately dial 911.

b. notify the supervisor/practitioner.

APPROVED BY: Dr._____ DATE: _____

Emergency Earthquake Plan

STAY CALM AT THE FIRST SIGN OF AN EARTHQUAKE.

Instruct any patients and staff to duck and cover under a sturdy desk, table, or other furniture.

Hold onto it and be prepared to move with it. Stay clear of windows.

Do not try to use stairs or elevators while the building is shaking or while there is danger of being hit by glass or falling debris. Do not rush outside or crowd exits.

After the Earthquake, check for any employee or patient injuries.

A. If person is not breathing, open the airway. If still not breathing, begin rescue breathing.

B. If person is bleeding put pressure over the wound.

C. Do not attempt to move seriously injured persons unless they are in immediate danger of further injury.

Immediately clean up any spilled medicines, drugs, or other potentially harmful materials.

Office first aid kit is located _____

Flashlights are located (highly recommended) _____

Examine the area for fire hazards and call 911 if there is a fire hazard.

Outside meeting place is _____

APPROVED BY: Dr._____ DATE: _____

Emergency Fire Plan

STAY CALM AT THE SIGN OF FIRE.

To report a fire Dial 911 and spell the last name of the doctor as it is listed on the building. _____, M.D. Office# is _____

Fire Extinguishers are located _____

EMPLOYEE _____ IS

To immediately assist all Patients in leaving the building and have them wait outside,

The designated outside meeting place for employees is _____

_____

All Employees are to review the emergency exit plan which is posted to initial the plan.

APPROVED BY: Dr._____ DATE: _____

SAMPLE

Sample Site evacuation Plan

Draw diagram of your office with clearly marked exits and evacuation route

PCP	Page 1 of 1
Section Access/Safety	
POLICY AND PROCEDURE: Medical and Lab Equipment Maintenance	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date: _____ Revised Date: _____

POLICY:
Medical and Laboratory equipment used for patient care shall be properly maintained.

PROCEDURE:

I. MAINTENANCE OF MEDICAL EQUIPMENT

A. Operating manuals for medical and lab equipment will be maintained on site.

B. Operating manuals will be the reference for planning routine maintenance Schedules for equipment.

C. If operating manuals are not available; an annual cycle for safety/calibration service will be adopted.

D. Documented proof of servicing will be maintained on site and may be in the following form:

1. A receipt listing all equipment serviced and date of service.
2. Stickers applied to equipment noting the date of service.
3. Work orders/receipts for repair of equipment.
4. A handwritten log with dates and results of calibration (such as for a Hemocue).

II. MALFUNCTIONING EQUIPMENT

A. Staff shall inform provider/designee of any equipment found to be malfunctioning or out of service.

1. Provider/designee will arrange for repair or replacement of Malfunctioning equipment.
2. Documented proof of repair will be maintained on site.

Ill. QUALIFIED PERSONNEL

A. Qualified staff assigned to operate equipment will be trained on appropriate use and maintenance.

SECTION: Access/Safety	
POLICY AND PROCEDURE: Emergency Health Care Services	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:_____

POLICY:

Emergency health care services shall be available and accessible twenty-four hours a day, seven days a week.

PROCEDURE:

I. EMERGENCY MEDICAL EQUIPMENT

A. Minimum emergency medical supplies/equipment, sufficient to establish and maintain a patent/open airway and manage anaphylactic reactions, shall be maintained in the facility. The equipment will include:

1. An oxygen tank which is secured.
2. An oxygen delivery system which includes tubing and mask/cannula and Adjustable Flow Meter (Oxygen Tank should be at least 3/4 full.
   - Providers may NOT use small oxygen tanks where the liter flow cannot be adjusted. There is no size requirement for the tank; however, it must reflect the content balance in increments of ¼, 1/2, or ¾ full and full. The oxygen should last long enough to handle an emergency until the arrival of the emergency medical response team.
   - Office staff will know how to turn on and regulate the oxygen flow.
3. Population-appropriate (infants/children/adults) ambu bag(s) and oral airway(s).
4. Epinephrine 1:1000 (injectable), Benadryl 25 mg oral, or Benadryl 50 mg./ml (injectable).
5. Tuberculin syringes, alcohol wipes.
6. Emergency medication dosage chart (see attached).

B. The supplies/equipment will be located "together" in an accessible location allowing for retrieval by all staff members without the use of assistive devices.

C. The supplies and equipment will be checked for expiration and operating status at least monthly. Staff responsible for checking the equipment/supplies will document:

1. The date supplies/equipment was checked, and
2. His/her initials verifying that equipment is in working order, the oxygen tank is full, the supplies are within expiration date and the medication dosage chart is present.

D. Replacing/restocking supplies:

1. An extra oxygen tank will be maintained onsite -OR- each time the oxygen is used, the remaining supply will be checked. If the tank is 3/4 or less full, the supplier will be called to replace the used tank with a full tank.
2. The month prior to the noted expiration date, the supplies/medication will be ordered to ensure delivery before the supplies actually expire.
3. The medication and supplies will be ordered/replaced immediately after use.

3. EMERGENCY SERVICES TRAINING

A. All staff members will be trained on the emergency medical protocol. Staff will be able to:

1. describe facility-specific actions, and
2. locate written emergency procedures and information.

B. Training will be completed upon hire and annually thereafter.

C. Training will be documented.

III. EMERGENCY INFORMATION

A. Emergency phone number contacts will be posted at the reception desk and at the work station.

ATTACHMENTS: Emergency Protocol (Sample)
Emergency Supplies Inventory Checklist
(Sample) Emergency Medication Dosage Chart

Emergency Medications Dosage Chart

Follow package insert for dosage determination

Epinephrine 1:1000 (Aqueous lml=lmg)

- May be repeated every 10-20 minutes up to 3 doses
- Maximum dose is 0.3ml regardless of age

Medication		Usual Dosage	
Epinephrine	Age		
Infants: 0.05-0.1 ml	Less than 6 months		ml
Children: 0.1-0.3 ml	6 months – 2 years		ml
	2 years – 5 years		ml
	6 years and older		ml
	Weight		
	Under 20 lbs		ml
	20-35 lbs		ml
	35-50 lbs		ml
Adolescents/Adults 0.3ml	50-100lbs		ml
Benadryl Oral 25 mg Injection 50 mg		Oral	Injection
Children	Under 2 years	mg PO	mg IM
	2-4 years	mg PO	mg IM
	5-11 years	mg PO	mg IM
Adults	12 years and older	mg PO	mg IM

SAMPLE

Emergency Protocol

IN THE EVENT OF A MEDICAL EMERGENCY:

_____ is to call 911.

_____ is to start CPR.

_____ is to bring the ER supplies to the patient.

_____ is to bring the Oxygen to the patient.

_____ is to attend to other patients.

LOCATION OF EMERGENCY SUPPLIES: _____

_____

LOCATION OF OXYGEN (full tank, tubing & mask/cannula): _____

_____

APPROVED BY: _____ DATE: _____

Emergency Supplies Inventory Checklist

YEAR _____

Supplies & Equipment	JAN ____	FEB ____	MAR ____	APR ____	MAY ____	JUN ____	JUL ____	AUG ____	SEP ____	OCT ____	NOV ____	DEC ____
Oxygen (Full)												
Tubing/Cannula												
Ambu Bags												
Oral Airways (set)												
Epinephrine (with Exp. Dates)												
Benadryl 25mg PO and/or 50mg/mL IM (with Exp. Dates)												
TB syringes & Safety Needles												
Alcohol Wipes												
Dosage chart												

Print Name: _____ Signature: _____ Initials: _____

Print Name: _____ Signature: _____ Initials: _____

Print Name: _____ Signature: _____ Initials: _____

Print Name: _____ Signature: _____ Initials: _____

Print Name: _____ Signature: _____ Initials: _____

*Print name, sign, and initial above.

*Document day of the month and initial when equipment is verified to be in working order, medications are within expiration dates, oxygen tank is full and medication dosage chart is present.

MONTHLY EQUIPMENT, MEDICATION VERIFICATION and REPLACEMENT LOG

YEAR: _____

Month/Date	Medications in Fridge/ Freezer	All other meds and samples	Emergency Equipment/ Meds used & replaced	Oxygen level, key, mask, and tubing attached	All Lab reagents, hemocults, etc.	All vacutainers, tubes, cultures, etc.	Other
JAN _____							
FEB _____							
MAR _____							
APR _____							
MAY _____							
JUN _____							
JUL _____							
AUG _____							
SEP _____							
OCT _____							
NOV _____							
DEC _____							

Print Name: _____ Signature: _____ Initials: _____
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Print Name: _____ Signature: _____ Initials: _____
Print Name: _____ Signature: _____ Initials: _____
Print Name: _____ Signature: _____ Initials: _____

*Print name, sign, and initial above.

*Initial each category as you check the medication and equipment.

*An initial indicates that the items have been checked; expired medications and lab supplies purged, properly disposed of and replaced

PCP	Page 1 of 2
SECTION: Personnel	
POLICY AND PROCEDURE: Staff Qualifications	Approved Date:_____ Approved By:_____ Effective Date: _____ Revised Date :_____ Revised Date :_____

POLICY:

All professional health care personnel must have current California licenses and certifications and must be qualified and trained for assigned responsibilities.

PROCEDURE:

I. HEALTH CARE LICENSE AND CERTIFICATION REQUIREMENTS

A. All medical professional licenses and certifications must be current and issued from the appropriate agency to practice in California. Copies and/or lists of currently certified or credentialed personnel must be readily available when requested by reviewers.

Medical Professional	License/Certification	Issuing Agency
Certified Nurse Midwife	RN License and Nurse- Midwife certificate	CA Board of Registered Nursing
Certified Radiological Technologist (CRT)	CRT Certificate	CA Department of Public Health (Radiological Branch)
Doctor of Osteopathy (DO)	Physician's & Surgeon's Certificate, DEA Registration	Osteopathic Medical Board of CA, Drug Enforcement Administration
Licensed Vocational Nurse (LVN)	LVN License	CA Board of Vocational Nursing and Psychiatric Technicians
Nurse Practitioner (NP)	RN License with NP Certification and Furnishing Number	CA Board of Registered Nursing
Pharmacist (Pharm.D)	Pharmacist License	CA State Board of Pharmacy
Physician/Surgeon (MD)	Physician's & Surgeon's Certificate, DEA Registration	Medical Board of CA, Drug Enforcement Administration
Physician's Assistant (PA)	PA License	Physician Assistant Examining Committee / Medical Board of CA
Radiological Technician	Limited Permit	CA Department of Health Care Services (Radiological Branch)
Registered Dietitian	RD Registration Card	Commission on Dietetic Registration
Registered Nurse	RN license	CA Board of Registered Nursing

II. IDENTIFICATION OF HEALTH CARE PRACTITIONERS

A. A health care practitioner shall disclose his or her name and practitioner's license status, as granted by the State of California, on a nametag with at least 18-point type. A health care practitioner in a practice or office, whose license is prominently displayed, may opt not to wear a nametag.

Note: It is unlawful for any person to use the title "nurse" in reference to himself or herself, in any capacity, except for an individual who is a registered nurse or licensed vocational nurse.

III. TRAINING OF SITE PERSONNEL

A. Personnel on site must be qualified for their responsibilities and adequately trained for their scope of work. Site staff should have a general understanding of the systems/processes in place, appropriate supervisions, and knowledge of the available sources of information on site.

B. Provider and staff must be able to demonstrate operation of medical equipment used in their scope of work.

POLICY:
Physician offices will have standardized procedures that clearly define the scope of services and supervision of all non-physician medical providers (NPMP).

PROCEDURE:

I. SCOPE OF PRACTICE OF NON-PHYSICIAN MEDICAL PRACTITIONERS

A. Standardized procedures defining the scope of practice of Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants must be documented on-site. Standardized procedures identify the furnishing of drugs or devices, extent of physician supervision, method of periodic review of competence, and review of provisions in the standardized procedures.

B. Standardized procedures shall undergo periodic review, with signed, dated revisions completed at each change in scope of work.

Certified Nurse Midwife (CNM): The certificate to practice nurse mid-wifery authorizes the holder, under supervision of a licensed physician, to attend cases of normal childbirth and to provide prenatal,intrapartum ,and postpartum care, including family planning care for the mother and immediate care for the newborn. The supervising and back-up physician for the CNM must be credentialed to perform obstetrical care in the same delivering facility in which the CNM has delivery privileges.

Nurse Practitioner (NP): Nurse practitioners may provide primary care and perform advanced procedures. The extent of required supervision must be specified in the standardized procedures.

Physician Assistants (PA): Every PA is required to have the following documents:

1. Delegation of Services Agreement: Defines specific procedures identified In practice protocols or specifically authorized by the supervising physician, and must be dated and signed by the physician and PA. An original or copy must be readily accessible at all practice sites in which the PA works.

- The Agreement will be revised, dated, and signed anytime changes occur. Failure to maintain a Delegation of Services Agreement is

Violation of the Physician Assistant Regulations and is grounds for disciplinary action by the Medical Board of California against a physician assistant's licensure.

2. Approved Supervising Physician's Responsibility for Supervision of Physician Assistants Agreement: Defines supervision responsibilities and methods required by Title 16, section 1399.545 of the Physician Assistant Regulations, and is signed by the physician. The following procedures must be identified:

o Transport and back-up procedures for when the supervising physician is not on the premises

o One or more methods for performing medical record review by the supervising physician

o Responsibility for physician review and countersigning of medical records

- Responsibility of the PA to enter the name of approved supervising physician responsible for the patient on the medical record

3. Each NP, CNM, and PA that prescribes controlled substances must have a valid DEA Registration Number.

II. SUPERVISION OF NON-PHYSICIAN MEDICAL PRACTITIONERS

A. The supervising physician holds ultimate responsibility for the practice of each supervised non-physician medical practitioner. The number of non-physician medical practitioners who may be supervised by a single primary care physician is limited to the full-time equivalent of **one** of the following:

The MD is permitted to supervise:

- Up to 4 Physician Assistants
- There is no limit to Nurse Practitioners the MD may supervise **UNLESS** the FNPs have Furnishings Licenses, then only a **Maximum of 4 Nurse Practitioners with a Furnishing License**
- A total of 8 equaling 4FNP and 4 PA's at one time and
- The MD may also supervise 4 Certified Nurse Midwives
  **This May bring the TOTAL number if mid levels supervised to 12
  Update per AB 2346; highlights may be found in the Medical Board of CA Newsletter Summer 2014.

B. The designated supervising or back-up physician is available in person or by electronic communicational all times when a NPMP is caring for patients.

III. IDENTIFICATION OF HEALTH CARE PRACTITIONERS

A. A health care practitioner shall disclose his or her name and practitioner's license status, as granted by the State of California, on a nametag with at least 18-point type. A health care practitioner in a practice or office, whose license is prominently displayed, may opt not to wear a nametag.

Note: It is unlawful for any person to use the title "nurse" in reference to himself or herself, in any capacity, except for an individual who is a registered nurse or licensed vocational nurse.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

BOARD OF REGISTERED NURSING
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AN EXPLANATION OF STANDARDIZED PROCEDURE REQUIREMENTS FOR NURSE PRACTITIONER PRACTICE

Standardized Procedures are authorized in the Business and Profession Code, Nursing Practice Act (NPA) Section 2725 and further clarified in California Code of Regulation (CCR 1480). Standardized procedures are the legal mechanism for registered nurses, nurse practitioners to perform functions which would otherwise be considered the practice of medicine. Standardized procedures must be developed collaboratively by nursing, medicine, and administration in the organized health care system where they will be utilized. Because of this interdisciplinary collaboration for the development and approval, there is accountability on several levels for the activities to be performed by the registered nurse, nurse practitioner.

Organized health care systems includes health facilities, acute care clinics, home health agencies, physician's offices and public or community health services. Standardized procedures means policies and protocols formulated by organized health care systems for the performance of standardized procedure functions.

The organized health care system including clinics, physician's offices (inclusive of sites listed above) must develop standardized procedures permitting registered nurse, nurse practitioner to perform standardized procedure functions. A registered nurse, nurse practitioner may perform standardized procedure functions only under the conditions specified in a health care system's standardized procedure; and **must provide the system with satisfactory evidence that the nurse meets its experience, training, and/or education requirements to perform the functions.**

A nurse practitioner is a registered nurse who possesses additional preparation and skill in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program conforming to the Board standards as specified in CCR 1484 (Standards of Education).

The Board of Registered Nursing has set educational standards for nurse practitioner certification which must be met in order to "hold out" as a nurse practitioner. Nurse practitioners who meet the education standards and are certified by the BRN are prepared to provide primary health care, (CCR 1480 b), that which occurs when a consumer makes contact with a health care provider who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease.

Scope of Medical Practice

The Medical Practice Act authorizes physicians **to diagnose** mental and physical conditions, **to use drugs in or** upon human beings, **to sever or penetrate the tissue** of human beings and **to use other methods** in the treatment of diseases, injuries, deformities or other physical or mental conditions. As a general guide, the performance of any of these functions by a registered nurse, nurse practitioner requires a standardized procedure.

Standardized Procedure Guidelines.

The Board of Registered Nursing and the Medical Board of California jointly promulgated the following guidelines. (Board of Registered Nursing, Title 16, California Code of Regulations (CCR) section 1474; Medical Board of California, Title 16, CCR Section 1379.)

(a) Standardized procedures shall include a written description of the method used in developing and approving them and any revision thereof.

(b) Each standardized procedure shall:

(1) **Be in writing, dated and signed by the organized health care system** personnel authorized to approve it.

(2) Specify **which standardized procedure functions** registered nurses may perform and under what circumstances.

(3) State any specific **requirements which are to be followed** by registered nurses in performing particular standardized procedure functions.

(4) Specify any **experience, training, and/or education** requirements for performance of standardized procedure functions.

(5) Establish a method for initial and continuing **evaluation** of the competence of those registered nurses authorized to perform standardized procedure functions.

(6) Provide for a method of maintaining a written record of those **persons authorized to perform** standardized procedure functions.

(7) Specify the scope of **supervision** required for performance of standardized procedure functions, for example, telephone contact with the physician.

(8) Set forth any specialized circumstances under which the registered nurse is to immediately **communicate with a patient's physician** concerning the patient's condition.

(9) State the limitations on **settings**, if any, in which standardized procedure functions may be performed.

(10) Specify patient **record-keeping** requirements.

(11) Provide for a method of **periodic review** of the standardized procedures.

An additional safeguard for the consumer is provided by steps four and five of the guidelines which, together, form a **requirement that the nurse be currently capable** to perform the procedure. If a RN or NP undertakes a procedure without the competence to do so, such an act may constitute gross negligence and be subject to discipline by the Board of Registered Nursing.

Standardized procedures which reference textbooks and other written resources in order to meet the requirements of Title 16, CCR Section 1474 (3), must include book (specify edition) or article title, page numbers and sections. Additionally, the standards of care established by the sources must be reviewed and authorized by the registered nurse, physician and administrator in the practice setting. A formulary may be developed and attached to the standardized procedure. Regardless of format used, whether a process protocol or disease-specific, the standardized procedure must include all eleven required elements as outlined in Title 16, CCR Section 1474.

SCOPE OF PRACTICE AND STANDARDIZED PROCEDURES
FOR NURSE PRACTITIONERS
Version 1

1. PURPOSE: To outline a policy and procedure for requesting approval of Scope of Practice and Standardized Procedures for nurse Practitioners (NPs), as well as define the scope of practice and standardized procedures of the NP's within the [Enter name of facility].

2. POLICY:

   A. This policy gives authorization to NPs and defines the general conditions for implementation of the Scope of Practice and Standardized Procedures as defined in this document and will be referred to generally as the "Standardized Procedures."

   B. By utilizing their assessment and health care management skills in accordance with the Standardized Procedures, NPs can diagnose, treat, and manage all patient situations to meet the health care needs of the patient.

   C. All Standardized Procedures are to be approved by the NP, collaborating physician, Director of the Service Line, Nurse Executive, and the Chief of Staff.

   D. The NP and collaborating physician will review the Scope of Practice and standardized procedures for that NP annually and when modification is deemed necessary. This review will utilize data obtained from the ongoing medical record peer review process. The review will be documented at the time of the annual verification of proficiency and competency. The Peer review process will be utilized for resolution of disagreements between the Nurse Practitioner and physician.

   E. The NP Scope of Practice and standardized procedures will be renewed every two (2) years.

3. DEFINITIONS: None Necessary.

4. RESPONSIBILITIES:

   A. The NP will manage primary, complex, and urgent/emergent medical problems within the primary, secondary, and tertiary care setting, as outlined in this document.

   B. The NP is authorized to implement the Standardized Procedures in this document (Attachment A).

   C. Physician consultation will be available at all times on site or by telephone.

   D. Consultation with a physician will be required:

(1) Whenever situations arise that go beyond the competence, scope of practice, experience of the NP, or the intent of the standardized procedures.

(2) Whenever a patient's condition fails to respond to the management plan in appropriate time or manner.

(3) For any patient conditions that are uncommon or unstable.

(4) For any patient conditions that do not fit the commonly accepted diagnostic patterns for a disease or disorder.

(5) For all emergency situations after initial stabilizing care has been started.

(6) For **significant** unexplained physical, historical, or laboratory findings.

(7) At the request of the patient, nurse practitioner, or physician.

F. Whenever physician consultation is obtained, a notation to that effect, including the physician's name will be made by the NP in the patient's medical record.

F. NPs will perform these standardized procedures at the [Enter name of facility].

G. The NP will be held responsible for the preparation of a complete medical record entry for each patient contact per existing policies.

H. The NP will provide for patient coverage in the case of absence, as needed.

5. PROCEDURES:

A. In addition to basic RN qualifications, each nurse practitioner performing these functions must have the following:

(1) Advanced education in a university-affiliated NP program or in an accredited university-based masters prepared NP program.

(2) Current state certification/licensure as an NP .

(3) Current American Nurses Association or other nationally recognized certification as an NP.

(4) A furnishing license as an NP in the State of California or a corresponding prescriptive authorization from the state of origin.

(a) In the State of California, to be eligible for a furnishing license the NP must have completed a BRN- approved pharmacology course and

have six (6) months of physician-supervised experience in furnishing drugs and devices.

B. The Credentialing and Privileging Office is responsible for:

(1) Verification of NP and collaborating physician credentials.

(2) Verification of competency documentation appropriate to Scope of Practice and Standardized Procedures.

(3) Processing, tracking, and maintaining Scope- of -Practice files on all NPs.

C. Evaluation of the NPs competence in performance of standardized procedure functions will be done in the following manner:

(1) **Initial**: at 3 months, 6 months, and 12 months by [Enter name and title] through feedback from colleagues, physicians, and chart review.

(2) **Routine**: annually after the first year by [Enter name and title] through feedback from colleagues, physicians, and chart review.

(3) **Follow-up**: areas requiring increased proficiency as determined by the initial or routine evaluation will be re-evaluated by [Enter name and title] at appropriate intervals until acceptable skill level is achieved, e.g. direct supervision.

D. The NP's Scope of Practice and Standardized Procedures will be reviewed and approved by the NP, collaborating physician, Director of the Service Line, Nurse Executive, and Chief of Staff.

6. REFERENCES:

7. REVIEW DATE: [Enter Date]

8. ATTACHMENTS:

Attachment A: Scope of Practice and standardized procedures for Nurse Practitioners.

Attachment B: Provider file request.

_____ _____

Name Date
Chief Executive Officer

FOR NURSE PRACTITIONERS

Attachment A

This Scope of Practice and Standardized Procedures are for:

_____, Nurse Practitioner

_____, Care line / Venue

(Check applicable items)

1. Definition: Standardized procedures address delivery of care for primary, complex and urgent/emergent medical problems, prescribing practices, and ordering/interpreting laboratory and diagnostic studies.

☐ A. Primary care is the provision of integrated, accessible health care services by clinicians that are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. The nurse practitioner is authorized to diagnose and treat primary care problems as follows:

(1) A treatment plan is developed, documented and based upon clinical guidelines/pathways and standards of practice.
(2) All other applicable procedures in this document are followed during patient care management.
(3) The polices regarding approval, setting, education, evaluation, patient records, supervision and consultation for the Nurse Practitioner are in force.

☐ B. Complex medical problems are those that fall beyond the scope of management of primary care but do not present as urgent/emergent medical conditions. The nurse practitioner is authorized to diagnose and treat complex medical problems and may practice as follows:

(1) A treatment plan is developed, documented and based upon clinical guidelines/pathways and standards of practice.
(2) Management of the patient may be in conjunction with a physician.
(3) The consultation or referral is documented in the patient's medical record.
(4) All other applicable procedures in this document are followed during patient care management.
(5) The polices regarding approval, setting, education, evaluation, patient records, supervision and consultation for the Nurse Practitioner are in force.

☐ C. The nurse practitioner is authorized to diagnose and treat urgent / emergent conditions as follows:

Initial evaluation and stabilization of the patient may be performed with concomitant notification of and/or immediate management by a physician.

(1) The consultation or referral is documented in the patient's medical record.
(2) All other applicable procedures in this document are followed during patient care management.
(3) The policies regarding approval, setting, education, evaluation, patient records, supervision and consultation for the Nurse Practitioner are in force.

☐ D. The nurse practitioner is authorized to order, collect and interpret laboratory and diagnostic studies as follows:

(1) Laboratory and diagnostic studies may be ordered as appropriate in accordance to clinical guidelines/pathways and standards of practice.
(2) Complex and/or invasive studies are ordered/obtained, utilizing physician consultation as appropriate.
(3) All other applicable procedures in this document are followed during patient care management.
(4) The policies regarding approval, setting, education, evaluation, patient records, supervision and consultation for the Nurse Practitioner are in force.

☐ E. The nurse practitioner may prescribe drugs or devices pursuant to [Enter name of facility], "General Guidelines for Establishing Medication Prescribing Authority". The nurse practitioner is authorized to prescribe medications or devices as follows:

(1) A treatment plan is developed, documented and based upon clinical guidelines/pathways and standards of practice.
(2) All other applicable procedures in this document are followed during patient care management.
(3) The policies regarding approval, setting, education, evaluation, patient records, supervision and consultation for the Nurse Practitioner are in force.

☐ F. Non-restricted legend and non-legend drugs and pharmaceutical devices, including schedule III through schedule V controlled substances, may be **RENEWED** within the [Enter name of facility] Formulary. A Drug Enforcement Agency number (DEA#) is required in order for the APN to prescribe controlled substances. In addition, prescribing of controlled substances schedule III will be in accordance with patient specific protocols in agreement with the collaborating physician (attachment C).

☐ G. Non-restricted legend and non-legend drugs and pharmaceutical devices, including schedule III through schedule V controlled substances, may be **INITIATED and/or MODIFIED** within the [Enter name of facility] Formulary. A Drug Enforcement Agency number (DEA#) is required in order for the APN to prescribe controlled substances. In addition, prescribing of controlled substances schedule III will be in accordance with patient specific protocols in agreement with the collaborating physician (attachment C).

☐ H. Nurse Practitioners assigned to sub-specialty areas are approved to **RENEW** drugs restricted to the specialty area, in accordance with clinical guidelines/pathways (see attached list).

☐ I. Nurse Practitioners assigned to sub-specialty areas are approved to **INITIATE and/or MODIFY** drugs restricted to the specialty area, in accordance with clinical guidelines/pathways (see attached list).

☐ J. Specialized Standardized Procedures (attached if applicable).

Recommended Approval: (signatures)

Nurse Practitioner: _____Date: _____

As collaborating physician for the above named Nurse Practitioner, I agree to supervise and regularly evaluate the performance of the Nurse Practitioner.

Collaborating Physician(s): _____ Date: _____

_____ Date: _____

Director of Service Line: _____Date: _____

Nurse Executive: _____ Date: _____

Chief of Staff: _____Date: _____

PROVIDER FILE REQUEST

Attachment B

Please answer the questions listed below for inclusion in the [Enter name of facility] provider file.

1. Name of Provider:
   _____
   (last, first, middle initial)

2. Sex: _____

3. Date of Birth: _____

4. Social Security Number: _____ _____ _____

5. Mailing Address: _____
   (number and street name)

   _____ _____ _____
   (city) (state) (zip code)

6. Class:
   _____
   (example: Dentist, Physician, Fellow, Intern, Pharmacy Specialist, Nurse Practitioner, Physician Assistant).

7. Type: _____ Enter 1 for full time
   Enter 2 for part-time
   Enter 3 for C & A
   Enter 4 for fee basis
   Enter 5 for house staff

8. DEA #: _____

9. [Enter name of facility] #: _____

10. License expiration date: _____

STATEMENT OF APPROVAL AND AGREEMENT

This document was jointly developed and approved by the Medical Director and Nurse Practitioner at (ENTER NAME OF SITE) in accordance with the codes regulating nursing practice.

By signing this Statement of Approval and Agreement, we, the below named Medical Director / Supervising Physician and the Nurse Practitioner (s)

- Approve the Standardized Procedure and all the Policies and Procedures contained in this document
- Agree to maintain a collaborative and collegial relationship.
- Agree to abide by the Standardized Procedure in theory and practice.

_____

NURSE PRACTITIONER SIGNATURE PRINTED NAME DATE

_____

MEDICAL DIRECTOR / SUPERVISING PHYSICIAN PRINTED NAME DATE

Delegation of Services Agreements – Change in Regulations

Title 16, Division 13.8, Article 4, section 1399.540 was amended to include several requirements for the delegation of medical services to a physician assistant. There are four specific changes with this amendment:

Background:

The Delegation of Services Agreement (DSA) is a document used by supervising physicians and physician assistants to meet requirements of Section 1399.540. The DSA is the foundation of the relationship between a supervising physician and the physician assistant, and specifies the names of the supervising physicians and what types of medical services the physician assistant is allowed to perform, how they are performed, how the patient charts will be reviewed and countersigned, and what type of medications the physician assistant will transmit on behalf of the supervising physician.

Regulatory Requirements:

1) A physician assistant may provide medical services, which are delegated in writing by a supervising physician who is responsible for patients, cared for by the physician assistant. The physician assistant may only provide services which he or she is competent to perform, which are consistent with their education, training and experience, and which are delegated by the supervising physician.

2) The delegation of services agreement is the name of the document, which delegates the medical services. More than one supervising physician may sign the delegation of services agreement only if each supervising physician has delegated the same medical services. A physician assistant may provide medical services pursuant to more than one delegation of services agreement.

3) The Physician Assistant Board or their representative may require proof or demonstration of competence from any physician assistant for any medical services performed.

4) If a physician assistant determines a task, procedure or diagnostic problem exceeds his or her level of competence, and then the physician assistant shall either consult with a physician or refer such cases to a physician.

Question: What if a physician assistant works for more than one supervising physician at a hospital or clinic? Do we need to have separate DSAs for each supervising physician?

Answer: The Board has had questions regarding how the DSA would be written if a physician assistant works for more than one supervising physician at a hospital or clinic. If the duties and medical services performed are consistent with each supervising physician, then one DSA can be written to include several supervising physicians. Each supervising physician must sign and date the DSA, along with the signature of the physician assistant.

Question: What if a physician assistant works for one supervising physician who is an ob-gyn, and also works for an ortho supervising physician, and both are at the same clinic or hospital?

Answer: If the duties and medical services provided by the physician assistant differ from one supervising physician to another, then it is recommended that a separate DSA be written for each supervising physician. However, one DSA could be used, but it would need to be separated with which duties are allowed under each supervising physician. Again, signatures and dates from all parties must be included on the DSA.

Question: What if the physician assistant works at several different clinics – can one DSA be written?

Answer: A separate DSA should be made for each hospital or clinic, regardless of how many supervising physicians the physician assistant works with.

Alternatively, a physician assistant may have a DSA that specifies what services can be provided at a specific site.

Question: How long should I retain my DSA?

Answer: You should retain the DSA as long as it is valid. Additionally, it is recommended that you keep a copy of your DSA for at least one to three years after it is no longer the current DSA in case you need to reference the document. However, there is no legal requirement to retain the DSA once it is no longer valid and current.

DELEGATION OF SERVICES AGREEMENT
BETWEEN
A SUPERVISING PHYSICIAN AND A PHYSICIAN ASSISTANT
and
SUPERVISING PHYSICIAN'S RESPONSIBILITY FOR SUPERVISION OF A PHYSICIAN ASSISTANT

Title 16, Section 1399.540 of the Physician Assistant Regulations states, in part, "A physician assistant may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant. b) The writing which delegates the medical services shall be known as a delegation of services agreement. A delegation of services agreement shall be signed and dated by the physician assistant and each supervising physician. A delegation of services agreement may be signed by more than one supervising physician only if the same medical services have been delegated by each supervising physician. A physician assistant may provide medical services pursuant to more than one delegation of services agreement."

The following two sample documents are attached to assist you with meeting this legal requirement:

- Delegation of Services Agreement (DSA) Between Supervising Physician and Physician Assistant; and,
- Supervising Physician's Responsibility for Supervision of Physician Assistant Agreement.

These are sample documents. They are for your convenience, information, and use. Please feel free to duplicate or modify them as appropriate and consistent with law.

If you choose not to use the sample documents, please be aware that you are still required by law to execute a DSA with your supervising physician. The DSA must be signed and dated by you and your supervising physician. The original or a copy of this document should be maintained at all practice sites where the physician assistant practices, and should be readily accessible. It is recommended that you retain prior DSAs for one to three years after the DSA is no longer current or valid.

While every practicing physician assistant is required to have a DSA, you are **not** required to submit it to the Physician Assistant Board. If requested, you must make a copy of your DSA available to any authorized agent of the Medical Board of California, the Osteopathic Medical Board of California, or the Physician Assistant Board who may request it.

Failure to have a current DSA constitutes a violation of the Physician Assistant Regulations and is grounds for disciplinary action against a physician assistant's license. In addition, failure by the physician assistant and supervising physician to comply with the supervision requirements specified in the Physician Assistant Regulations and in the Delegation of Services Agreement is ground for disciplinary action.

THE ATTACHED DOCUMENTS DO NOT NEED TO BE RETURNED TO THE PHYSICIAN ASSISTANT BOARD

SAMPLE
DELEGATION OF SERVICES AGREEMENT BETWEEN SUPERVISING PHYSICIAN AND PHYSICIAN ASSISTANT (Title 16, CCR, Section 1399.540)

PHYSICIAN ASSISTANT_____
(Name)

Physician assistant, graduated from the _____
(Name of PA Training Program)

physician assistant training program on _____.
(Date)

He/she took (or is to take) the licensing examination for physician assistants recognized by the State of California (e.g., Physician Assistant National Certifying Examination or a specialty examination given by the State of California) on _____.
(Date)

He/she was first granted licensure by the Physician Assistant Board on _____, which expires on _____, unless renewed.
(Date) (Date)

SUPERVISION REQUIRED. The physician assistant named above (hereinafter referred to as PA) will be supervised in accordance with the written supervisor guidelines required by Section 3502 of the Business and Professions Code and Section 1399.545 of the Physician Assistant Regulations. The written supervisor guidelines are incorporated with the attached document entitled, "Supervising Physician's Responsibility for Supervision of Physician Assistants."

AUTHORIZED SERVICES. The PA is authorized by the physician whose name and signature appear below to perform all the tasks set forth in subsections (a), (d), (e), (f), and (g) of Section 1399.541 of the Physician Assistant Regulations, when acting under the supervision of the herein named physician. (In lieu of listing specific lab procedures, etc. the PA and *supervising* physician may state as follows: "Those procedures specified in the practice protocols or which the supervising physician specifically authorizes.")

The PA is authorized to perform the following laboratory and screening procedures:

_____

_____

The PA is authorized to assist in the performance of the following laboratory and screening procedures:

_____

_____

The PA is authorized to perform the following therapeutic procedures:

_____

_____

The PA is authorized to assist in the performance of the following therapeutic procedures:

_____

_____

The PA is authorized to function as my agent per bylaws and/or rules and regulations of (name of hospital):

_____

_____

a) The PA is authorized to write and sign drug orders for Schedule: II, III, IV, V without advance approval (circle authorized Schedule(s). The PA has taken and passed the drug course approved by the Board on _____ (attach certificate). DEA #:_____.
Date

or

b) The PA is authorized to write and sign drug orders for Schedule: II, III, IV, V with advance patient specific approval (circle authorized Schedule(s). DEA #:_____.

CONSULTATION REQUIREMENTS. The PA is required to always and immediately seek consultation on the following types of patients and situations (e.g., patient's failure to respond to therapy; physician assistant's uncertainty of diagnosis; patient's desire to see physician; any conditions which the physician assistant feels exceeds his/her ability to manage, etc.)

_____
(List Types of Patients and Situations)

_____

MEDICAL DEVICES AND PHYSICIAN'S PRESCRIPTIONS. The PA may transmit by telephone to a pharmacist, and orally or in writing on a patient's medical record or a written prescription drug order, the supervising physician's prescription in accordance with Section 3502.1 of the Business and Professions Code.

The supervising physician authorizes the delegation and use of the drug order form under the established practice protocols and drug formulary. _____ YES _____ NO

The PA may also enter a drug order on the medical record of a patient at _____
(Name of Institution)
in accordance with the Physician Assistant Regulations and other applicable laws and regulations.

Any medication handed to a patient by the PA shall be authorized by the supervising physician's prescription and be prepackaged and labeled in accordance with Sections 4076 of the Business and Professions Code.

PRACTICE SITE. All approved tasks may be performed for care of patients in this office or clinic located at _____ and, in _____ hospital(s) and
(Address / City) (Address / City)
_____ skilled nursing facility (facilities) for care of
(Name of Facility)
patients admitted to those institutions by physician(s) _____ .
(Name/s))

EMERGENCY TRANSPORT AND BACKUP. In a medical emergency, telephone the 911 operator to summon an ambulance.

The _____ emergency room at _____
(Name of Hospital) (Phone Number)
is to be notified that a patient with an emergency problem is being transported to them for immediate admission. Give the name of the admitting physician. Tell the ambulance crew where to take the patient and brief them on known and suspected health condition of the patient.
Notify _____ at _____ immediately
(Name of Physician) (Phone Number/s))
(or within _____ minutes).

PHYSICIAN ASSISTANT DECLARATION
My signature below signifies that I fully understand the foregoing Delegation of Services Agreement, having received a copy of it for my possession and guidance, and agree to comply with its terms without reservations.

_____ _____
Date Physician's Signature (Required)

_____
Physician's Printed Name

_____ _____
Date Physician Assistant's Signature (Required)

_____
Physician Assistant's Printed Name

SAMPLE ONLY

SUPERVISING PHYSICIAN'S RESPONSIBILITY
FOR SUPERVISION OF PHYSICIAN ASSISTANT

SUPERVISOR_____, M.D./D.O. is licensed to practice in California as a physician and surgeon with medical license number _____. Hereinafter, the above named physician shall be referred to as the supervising physician.

SUPERVISION REQUIRED. The physician assistant (PA) named in the attached Delegation of Services Agreement will be supervised by the supervising physician in accordance with these guidelines, set forth as required by Section 3502 of the Business and Professions Code and Section 1399.545 of the Physician Assistant Regulations, which have been read by the physician whose signature appears below.

The physician shall review, countersign, and date within seven (7) days the medical record of any patient cared for by the physician assistant for whom the physician's prescription for Schedule II medications was transmitted or carried out.

REPORTING OF PHYSICIAN ASSISTANT SUPERVISION. Each time the physician assistant provides care for a patient and enters his or her name, signature, initials, or computer code on a patient's record, chart or written order, the physician assistant shall also enter the name of his or her supervising physician who is responsible for the patient. When the physician assistant transmits an oral order, he or she shall also state the name of the supervising physician responsible for the patient.

MEDICAL RECORD REVIEW. One or more of the following mechanisms, as indicated below, by a check mark (x), shall be utilized by the supervising physician to partially fulfill his/her obligation to adequately supervise the actions of the physician assistant named _____.
(Name of PA)

_____ Examination of the patient by a supervising physician the same day as care is given by the PA.

_____ The supervising physician shall review, audit, and countersign every medical record written by the PA within _____ of the encounter.
(Number of Days May- Not Exceed 30 Days)

_____ The physician shall audit the medical records of at least 5% of patients seen by the PA under any protocols which shall be adopted by the supervising physician and the physician assistant. The physician shall select for review those cases which by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

_____ Other mechanisms approved in advance by the Physician Assistant Board may be used. Written documentation of those mechanisms is located at _____.
(Give Location)

BACK UP PROCEDURES: In the event this supervising physician is not available when needed, the following physician(s) has (have) agreed to be a consultant(s) and/or to receive referrals:

_____Phone: _____
(Printed Name and Specialty)

_____Phone: _____
(Printed Name and Specialty)

PROTOCOLS NOTE: This document **does not** meet the regulation requirement to serve as a protocol. Protocols, if adopted by the supervising physician, must fully comply with the requirements authorized in Section 3502 (c) (1) of the Business and Professions Code.

_____ _____
Date Physician's Signature

THIS DOCUMENT IS NOT TO BE RETURNED TO THE BOARD
SAMPLE ONLY

Physician and Non-Physician Medical Provider Agreement Regarding Medical Assistants

This agreement is to state whether certain procedures and technical support services a Medical Assistant is allowed to perform under the supervision of a mid-level provider when the physician is not present.

Per the Medical Board of California, Medical Assistant description, medical assistants are unlicensed individuals who perform non-invasive routine technical support services under the supervision of a licensed physician and surgeon, podiatrist, physician assistant, nurse practitioner, or nurse midwife in a medical office or clinic setting without the need of receiving a certification. The supervising physician must be on the premises in order for the medical assistant to perform non-invasive technical support services. The only exception is outlined in B&P Code, Section 2069(a)(1) and H&S code 1204(a) which applies only to licensed "coMCQMDnity clinics" or "free clinics." In a clinic licensed under H&S code 1204(a) an MA may perform all these tasks and services under the supervision of a mid-level practitioner with written instructions from the physician (B&P Code, Section 2069(a)(1).

My signature below signifies that I fully understand the Medical Assistant and Provider Agreement, having received a copy of it for my possession and guidance, and agree to comply with its terms without reservations.

Physician's Signature: _____

Physician's Name: _____ Date: _____

Non-Physician Provider's Signature: _____

Provider's Name: _____ Date: _____

NOTIFICATION TO CONSUMERS REGULATION

Effective August 11, 2011, Section 1399.547, Title 16 of the California Code of Regulations, mandated by Business and Professions Code section 138, requires that physician assistants inform patients that they are licensed and regulated by the Physician Assistant Board. The notification must include the following statement and information:

NOTIFICATION TO CONSUMERS
PHYSICIAN ASSISTANTS ARE LICENSED AND REGULATED BY THE PHYSICIAN ASSISTANT BOARD
(916) 561.8780
WWW.PAC.CA.GOV

Physician assistants may provide this notification by one of the following three methods:

- Prominently posting a sign in an area of their offices conspicuous to patients, in at least 48-point type in Arial font.

- Including the notification in a written statement, signed and dated by the patient or patient's representative, and kept in that patient's file, stating the patient understands the physician is licensed and regulated by the Board.

- Including the notification in a statement on letterhead, discharge instructions, or other document given to a patient or the patient's representative, where the notification is placed immediately above the signature line for the patient in at least 14-point type.

For more information, please contact the Board at (916) 561.8780 or pacommittee@mbc.ca.gov.

1399.547. Notification to Consumers.

(a) A licensee engaged in providing medical services shall provide notification to each patient of the fact that the licensee is licensed and regulated by the board. The notification shall include the following statement and information:

NOTIFICATION TO CONSUMERS

Physician assistants are licensed and regulated

by the Physician Assistant Board

(916) 561-8780

www.pac.ca.gov

(b) The notification required by this section shall be provided by one of the following methods:

(1) Prominently posting the notification in an area visible to patients on the premises where the licensee provides the licensed services, in which case the notice shall be in at least 48-point type in Arial font.

(2) Including the notification in a written statement, signed and dated by the patient or the patient's representative and retained in that patient's medical records, stating the patient understands the physician assistant is licensed and regulated by the board.

(3) Including the notification in a statement on letterhead, discharge instructions, or other document given to a patient or the patient's representative, where the notice is placed immediately above the signature line for the patient in at least 14-point type.

Note: Authority cited: Section 3510, Business and Professions Code. Reference: Section 138, Business and Professions Code.

NOTIFICATION TO CONSUMERS

Physician Assistants are licensed and regulated by the Physician Assistant Board

(916) 561-8780

www.pac.ca.gov

MEDICAL BOARD OF CALIFORNIA
Notice to Consumers by Physicians
Specific Language of Proposed Changes

Adopt section 1355.4 in Article 1 of Chapter 2 to read as follows:

1355.4. Notice to Consumers

(a) A licensee engaged in the practice of medicine shall provide notice to each patient of the fact that the licensee is licensed and regulated by the board. The notice shall include the following statement and information:

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated

by the Medical Board of California

(800) 633-2322

www.mbc.ca.gov

(b) The notice required by this section shall be provided by one of the following methods:

(1) Prominently posting the notice in an area visible to patients on the premises where the licensee provides the licensed services, in which case the notice shall be in at least 48-point type in Arial font.

(2) Including the notice in a written statement, signed and dated by the patient or the patient's representative and retained in that patient's medical records, stating the patient understands the physician is licensed and regulated by the board.

(3) Including the notice in a statement on letterhead, discharge instructions, or other document given to a patient or the patient's representative, where the notice is placed immediately above the signature line for the patient in at least 14-point type.

NOTE: Authority cited: Section 2018, Business and Professions Code; Reference: Sections 138 and 680, Business and Professions Code.

NOTICE TO CONSUMERS

Medical doctors are
licensed and regulated by
the Medical Board of California

(800) 633-2322

www.mbc.ca.gov

POLICY:

All professional health care personnel must be qualified and trained for assigned responsibilities.

PROCEDURE:

I. MEDICAL ASSISTANTS

A. Medical Assistants (MA) are unlicensed health personnel who perform basic administrative, clerical, and non-invasive routine technical supportive services under the supervision of a licensed physician. The licensed physician must be physically present in the treatment facility during the performance of authorized procedures by the MA.

B. Training may be administered under a licensed physician; or under a RN, LVN, PA, or other qualified medical assistant acting under the direction of a licensed physician. The supervising physician is responsible for determining the training content and ascertaining proficiency of the MA. Training documentation must be maintained on-site and include the following:

- Diploma or certification from an accredited training program/school, or
- Letter/statement from the current supervising physician that certifies in writing: date, location, content, and duration of training, demonstrated proficiency to perform current assigned scope of work, and signature.

II. MEDICATIONS

A. Unlicensed staff must have evidence of appropriate training and supervision in all medication administration methods performed within their scope of work.
   - Medication administration by a MA means the direct application of pre-measured medication orally, sublingually, topically, vaginally, or rectally; or by providing a single dose to a patient for immediate self- administration by inhalation or simple injection.
   - The pre-labeled medication container must be shown to the licensed person prior to administration.
   - To administer medications by subcutaneous or intramuscular injection, or to perform intradermal skin tests or venipunctures for withdrawing

Blood, MA must have completed at least the minimum number of training hours established in CCR, Title 16, Section 1366.1.

- An MA may administer injections of scheduled drugs, including narcotic medications, only if the dosage is verified and the injection is intradermal, subcutaneous, or intramuscular.
- Medical assistants may not place an intravenous needle, start or disconnect the intravenous infusion tube, administer medications or injections into an intravenous line, or administer anesthesia.
- The supervising physician must specifically authorize all medications administered by an MA by means of a specific written or standing order prepared by the supervising physician.

Ill. IDENTIFICATION OF HEALTH CARE PRACTITIONERS

A. A health care practitioner shall disclose his or her name and practitioner's license status, as granted by the State of California, on a nametag with at least 18-point type. A health care practitioner in a practice or office, whose license is prominently displayed, may opt not to wear a nametag.

Note: It is unlawful for any person to use the title "nurse" in reference to himself or herself, in any capacity, except for an individual who is a registered nurse or licensed vocational nurse.

IV. TRAINING OF SITE PERSONNEL

A. Personnel on site must be qualified for their responsibilities and adequately trained for their scope of work. Site staff should have a general understanding of the systems/processes in place, appropriate supervisions, and knowledge of the available sources of information on site.

B. Provider and staff must be able to demonstrate operation of medical equipment used in their scope of work.

Medical Assistant Letter of Competency

To Whom It May Concern:

This is to certify that _____ has demonstrated and completed a **minimum of ten (10) clock hours** of on-the-job training, for the procedures specified below, at _____ under the auspices of the undersigned as follows and in compliance with Business Professions code Sections 2069 – 2070 and California Code of Regulations Title 16, Article 2, Section 1366 – 1366.4 .

Check all boxes that apply:

[ ] A. Administering injections and performing skin tests.

[ ] B. Venipuncture and skin puncture for the purpose of withdrawing blood.

[ ] C. Satisfactory performance by the trainee of at least ten (10) each of intramuscular, subcutaneous, and intradermal injections and ten (10) skin tests, and/or at least ten (10) venipuncture and ten (10) skin punctures.

[ ] D. Administering medication by inhalation.

Training in A through D included instruction and demonstration in:

1. **Pertinent anatomy and physiology appropriate to the procedures**
2. **Knowledge and correct use of all medical equipment they are expected to operate within their scope of work**
3. **Proper technique including sterile technique**
4. **Hazards and complications**
5. **The ability to perform all testing operations reliably and to report results accurately**
6. **Patient care following treatments and tests**
7. **Emergency procedures**
8. **California laws and regulations for Medical Assistants**

[ ] E. Appropriate training and supervision in all medication administration methods performed within their scope of work.

[ ] F. Demonstrates competency in performing vital signs. (Oral/tympanic/rectal temperature, respirations, apical/radial pulse, blood pressure, height/length, and weight.)

[ ] G. Demonstrates competency in performing Snellen screening and audiometric screening.

[ ] H. Demonstrates competency in operating autoclave and/or cold sterilization.

[ ] I Demonstrates competency in performing EKG's.

[ ] J. Demonstrates competency relaying member's medical information and provider instructions back to the member.

_____	_____	_____
Physician's Name	Physician's Signature	Date

PCP	Page 1 of 1
Section : Personnel	
POLICY AND PROCEDURE: Personnel Staff Education Training	Approved Date:_____ Approved By: _____ Effective Date :_____ Revised Date :_____ Revised Date :_____

That all staff at PCP sites receives education/training regarding safety issues, information on Members' rights and other issues related to clinical procedures. This education/training should take place initially upon hire, then annually thereafter for those areas identified with an asterisk on the Checklist.

PROCEDURE:

I. NEW HIRE PROCESS

A. Upon hire, all new employees will receive training on safety, Members' rights and clinical procedures as outlined in the attached checklists.

B. Types of training may include, but is not limited to: new employee orientation, in- service training, instructional videos, educational materials, annual training renewal, etc.

C. Upon completion of each criterion within this education/training, the employee's supervisor will initial the Checklist with the corresponding date of completion. The supervisor's initials indicate the employee either stated or demonstrated an understanding of the education/training provided.

1. When all areas on the Checklist have been completed, the employee and the instructor will sign and date the Checklist, signifying the employee was knowledgeable of all criteria presented by the instructor.

2. A copy of the completed Checklist shall be kept in each employee's file. All records of education/training need to be kept for three years.

D. ANNUAL REVIEW

E. All employees must receive an annual renewal of all training/education identified with an asterisk on the Checklist.

F. Follow the same procedure as described above, for the New Employee.

ATTACHMENTS: Sample of Training Checklist Log

blue california | Promise Health Plan

PHYSICIAN OFFICE STAFF EDUCATION CHECKLIST

Office of: _____ Address: _____

Employee Name: _____ Title: _____

ANNUAL STAFF EDUCATION IS COMPLETED FOR THE FOLLOWING TOPICS	EDUCATION FORMAT: LECTURE, SELF-LEARNING, MATERIALS	STAFF SIGNATURE	EDUCATION UPON HIRE DATE	ANNUAL RE-EDUCATION DATE(S)		
Infection control/Universal Precautions Section 30						
Blood Borne Pathogens Exposure Prevention Section 28						
Biohazardous Waste Handling Section 28						
STAFF EDUCATION FOR FOLLOWING TOPICS IS COMPLETED UPON HIRE AND THEN AS NEEDED				RE-EDUCATION DATES		
Fire Safety/Precautions Section 3						
Emergency Non-Medical Procedures Section 3						
Emergency Medical Procedures Section 5						
Child/Elder Abuse/Domestic Violence Reporting Sections 10,11,12						
Patient Confidentiality						
Informed Consent, including human sterilization Section 13						
Prior authorization requests/Referral Process Section 15						
Grievance/Complaint Procedure Section 16						
Sensitive Services/Minors Rights Section 14						
Health Plan Referral Process/Procedure/Resources -Section 15						
Other						

PCP:	Page 1 of 6
SECTION: Personnel	
POLICY AND PROCEDURE: Personnel Training: Child Abuse Reporting	Approved date:_____ Approved By: _____ Effective date: _____ Revised date: _____ Revised date:_____

POLICY:

Health Care practitioners who have knowledge of or observe a child, in his or her Profession capacity or within the scope of his or her employment, whom he or she knows or reasonably suspects, has been the victim of child abuse or neglect shall report the suspected incident of abuse or neglect to a "child protective agency".

PROCEDURE:

I. Reporting

A. The report must be made to a "child protective agency". A child protective agency is a county welfare or probation department or a police or sheriff's department (P.C. 11165.9, P.C. 11166[a])

1. Written reports must be submitted on a Department of Justice form – Form SS 8572 (DOJ SS 8572) which can be requested from your local child protective agency

2. A report must be made immediately (or as soon as possible) by phone

3. A written report must be forwarded to the child protective agency within 36 hours of receiving the information regarding the incident

4. A single report may be made if two or more persons have knowledge of suspected child abuse or neglect

5. Have the following information ready to report:
   - Name of reporter
   - Name and present location of the child
   - Nature and extent of the injury, and any evidence of prior abuse
   - Any other information, including what led you to suspect child abuse, if requested by the child protective agency (P.C. § 11167 [a])

6. Failure to make a required report is a misdemeanor punishable by up to six months in jail and/or up to a $1,000 fine (P.C. 1172[e]). Persons Who fail to report can also be subject to a civil lawsuit, and found liable for damages, especially if the child-victim or another child is further victimized because of the failure to report

II. Indicators of Abuse

A. Physical Abuse

1. Physical Indicators of Physical Abuse

- Fractures, lacerations, bruises that cannot be explained, or explanations which are improbable given the extent of the injury
- Burns (cigarette, rope, scalding water, iron, radiator)
- Infected burns, indicating delay in seeking treatment
- Facial injuries (black eyes, broken jaw, broken nose, bloody nose, bloody or swollen lips) with implausible or nonexistent explanations
- Subdural hematomas, long-bone fractures, fracture in different states of healing
- Pattern of bruising (e.g., parallel or circular bruises) or bruises in different stages of discoloration, indicating repeated trauma over time

2. Behavioral Indications of Physical Abuse

- Hostile, aggressive, verbally abusive towards others
- Fearful or withdrawn behavior
- Self-destructive (self-mutilates, bangs head, etc.)
- Destructive (breaks windows, sets fires, etc.)
- Out-of-control behavior (seems angry, panics, easily agitated)
- Frightened of going home, frightened of parents/caretakers or, at the other extreme, is overprotective of parent(s) or caretaker(s)
- Attempts to hide injuries; wears excessive layers of clothing, especially in hot weather
- Difficulty sitting or walking
- Clingy, forms indiscriminate attachments
- Apprehensive when other children cry
- Wary of physical contact with adults
- Exhibits drastic behavioral changes in and out of parental/caretaker presence
- Suffers from seizures or vomiting
- Exhibits depression, suicide attempts, substance abuse, or sleeping and eating disorders

B. Sexual Abuse

1. Physical Indicators of Sexual Abuse; the following may be indicative of sexual abuse:

- Wears torn, stained, or bloody underclothing

- Physical trauma or irritation to the anal/genital area (pain, itching, swelling, bruising, bleeding, laceration, abrasions), especially if injuries are unexplained or there is an inconsistent explanation
- Knowledge of a child's history of previous or recurrent injuries/diseases
- Swelling or discharge from vagina/penis
- Visible lesions around mouth or genitals
- Complaint of lower abdominal pain
- Painful urination, defecation
- Sexually transmitted diseases
- Difficulty in walking or sitting due to genital or anal pain
- Psychosomatic symptoms (stomachaches, headaches)

2. Behavioral Indicators of Sexual Abuse
   - Sexualized behavior (has precocious knowledge of explicit sexual behavior and engages self or others in overt or repetitive sexual behavior)
   - Compulsive indiscreet masturbation
   - Excessive curiosity about sexual matters or genitalia (self or others)
   - Unusually seductive with classmates, teachers and other adults
   - Excessive concern about homosexuality, especially by boys

3. Behavioral Indicators of Sexual Abuse in Younger Children; the following may be exhibited by younger children who are experiencing sexual abuse:
   - Wetting pant, bed wetting or fecal soiling
   - Eating disturbances such as overeating, under eating
   - Fears or phobias
   - Compulsive behavior
   - School problems or significant change in school performance (attitude and grades)
   - Age-inappropriate behavior, including pseudomaturity or regressive behavior such as bed wetting or thumb sucking
   - Inability to concentrate
   - Drastic behavior changes
   - Speech disorders
   - Frightened of parent/caretaker or of going home

4. Behavioral Indicators of Sexual Abuse in Older Children and Adolescents; the following are behaviors that may be exhibited by older children and adolescents who are experiencing sexual abuse:
   - Withdrawal, clinical depression, apathy, chronic fatigue
   - Overly compliant behaviors
   - Poor hygiene or excessive bathing
   - Poor peer relations and social skills; inability to make friends; non-Participation in sports and social activities

- Acting out; running away; aggressive, antisocial, or delinquent behavior
- Alcohol or drug abuse
- Prostitution or excessive promiscuity
- School problems, frequent absences, sudden drop in school performance
- Refusal to dress to physical education
- Fearfulness of showers or restrooms; of home life, as demonstrated by arriving at school early or leaving late; of going outside or participating in familiar activities; of males (in cases of male perpetrator and female victim)
- Self-consciousness of body beyond that expected for age
- Sudden acquisition of money, new clothes, or gifts with no reasonable explanation
- Suicide attempt, self-mutilation, or other-destructive behavior
- Crying without provocation
- Setting fires
- Pseudo-mature (seems mature beyond chronological age)
- Eating disorders

C. Neglect

1. Physical Indicators of Neglect; Neglect may be suspected when one or more of the following conditions exist:
   - Failure to thrive- the child fails to gain weight at the expected rate for a normal child
   - Malnutrition or poorly balanced diet (bloated stomach, extremely thin, dry, flaking skin, pale, fainting)
   - Inappropriate dress for weather
   - Dirty unkempt, extremely offensive body odor
   - Unattended medical or dental conditions (e.g., infections, impetigo)
   - Evidence of poor or inadequate supervision for the child's age
2. Behavioral Indicators of Neglect
   - Clingy or indiscriminate attachment
   - Depressed, withdrawn, or apathetic
   - Antisocial or destructive behavior
   - Fearfulness
   - Substance abuse
   - Speech, eating, or habit disorders (biting, rocking, whining)
   - Often sleepy or hungry
   - Brings only candy, chips, and soda for lunch or consistently "forget" to bring food

Ill. Definitions

A. Physical abuse: characterized by physical injury (for example, bruises and fractures) resulting from punching, beating, kicking, biting, burning, or otherwise harming a child. Any injury resulting from physical punishment that requires medical treatment is considered outside the realm of normal disciplinary measures.

B. Neglect: the negligent treatment or the maltreatment of a child by a person Responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person.

C. Severe neglect: the negligent failure of a person having the care or custody of a child to protect the child from severe malnutrition or medically diagnosed nonorganic failure to thrive. "Severe neglect" also means those situations of neglect where any person having the care or custody of a child willfully
causes or permits the person or health of the child to be placed in a situation such that his or her person or heath is endangered, including the intentional failure to provide adequate food, clothing, shelter, or medical care.

D. Sexual abuse: refers to sexual assault or sexual exploitation

1. Sexual assault includes rape, statutory rape, rape in concert, incest, sodomy, and lewd or lascivious acts upon a child, oral copulation, sexual penetration, or child molestation. It includes, but is not limited to, all of the following:
   - Any penetration, however slight, of the vagina or anal opening of one person by the penis of another person, whether or not there is the emission of semen
   - Any sexual contact between the genitals or anal opening of one person and the mouth or tongue of another person
   - Any intrusion by one person into the genital or anal opening of another person, including the use of any object for this purpose, excepting acts performed for a valid medical reason
   - The intentional touching of the genitals or intimate parts (including the breasts, genital area, groin, inner thighs, and buttocks) or the clothing covering them, of a child, or of the perpetrator by a child, for purposes of sexual arousal or gratification, excepting acts that may reasonably be construed to be normal caretaker responsibilities; interaction with, or demonstrations of affection for, the child; or acts performed for a valid medical purpose
   - The intentional masturbation of the perpetrator's genitals in the presence of a child (P.C. 11165.1[b])

2. Sexual exploitation refers to any of the following:
   - Depicting a minor engaged in obscene acts in violation of law; preparing, selling, or distributing obscene matter that depicts minors; employment of minor to perform obscene acts
   - Any person who knowingly promotes, aids, or assists, employs, uses, persuades, induces, or coerces a child, or any person responsible for a

child's welfare, who knowingly permits or encourages a child to engage in, or assists other to engage in, prostitution or a live performance involving obscene sexual conduct, or to either pose or model alone or with others for purposes of preparing a film, photograph, negative,
Slide, drawing, painting, or other pictorial depiction, involving obscene Sexual conduct. "Person responsible for a child's welfare" means a parent, guardian, foster parent, or a licensed administrator or employee of a public or private residential home, residential school, or other residential institution

- Any person who depicts a child in, or who knowingly develops, duplicates, prints or exchanges, any film, photograph, video tape, negative, or slide in which a child is engaged in an act of obscene sexual conduct, except for those activities by law enforcement and prosecution agencies and other persons described in subdivisions {c) and (e) of Section 311.3 (P.C. 11165.1[c])

Print

SUSPECTED CHILD ABUSE REPORT

Reset Form

To Be Completed by **Mandated Child Abuse Reporters**
Pursuant to Penal Code Section 11166

PLEASE PRINT OR TYPE

CASE NAME: _____

CASE NUMBER: _____

A. REPORTING PARTY

NAME OF MANDATED REPORTER	TITLE	MANDATED REPORTER CATEGORY
REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS Street City Zip		DID MANDATED REPORTER WITNESS THE INCIDENT? ❒ YES ❒ NO
REPORTER'S TELEPHONE (DAYTIME) ( )	SIGNATURE	TODAY'S DATE

B. REPORT NOTIFICATION

❒ LAW ENFORCEMENT ❒ COUNTY PROBATION ❒ COUNTY WELFARE / CPS (Child Protective Services)	AGENCY	
ADDRESS Street City Zip		DATE/TIME OF PHONE CALL
OFFICIAL CONTACTED - TITLE		TELEPHONE ( )

C. VICTIM
One report per victim

NAME (LAST, FIRST, MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip		TELEPHONE ( )	
PRESENT LOCATION OF VICTIM	SCHOOL	CLASS	GRADE

PHYSICALLY DISABLED? ❒ YES ❒ NO	DEVELOPMENTALLY DISABLED? ❒ YES ❒ NO	OTHER DISABILITY (SPECIFY)	PRIMARY LANGUAGE SPOKEN IN HOME
IN FOSTER CARE? ❒ YES ❒ NO	IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: ❒ DAY CARE ❒ CHILD CARE CENTER ❒ FOSTER FAMILY HOME ❒ FAMILY FRIEND ❒ GROUP HOME OR INSTITUTION ❒ RELATIVE'S HOME		TYPE OF ABUSE *(CHECK ONE OR MORE)* ❒ PHYSICAL ❒ MENTAL ❒ SEXUAL ❒ NEGLECT ❒ OTHER (SPECIFY)
RELATIONSHIP TO SUSPECT	PHOTOS TAKEN? ❒ YES ❒ NO		DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ❒ YES ❒ NO ❒ UNK

D. INVOLVED PARTIES

VICTIM'S SIBLINGS

NAME	BIRTHDATE	SEX	ETHNICITY	NAME	BIRTHDATE	SEX	ETHNICITY
1.				3.			
2.				4.			

VICTIM'S PARENTS/GUARDIANS

NAME (LAST, FIRST, MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE ( )	BUSINESS PHONE ( )	
NAME (LAST, FIRST, MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE ( )	BUSINESS PHONE ( )	

SUSPECT

SUSPECT'S NAME (LAST, FIRST, MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	TELEPHONE ( )		
OTHER RELEVANT INFORMATION			

E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ❒ *IF MULTIPLE VICTIMS, INDICATE NUMBER:* _____

DATE / TIME OF INCIDENT	PLACE OF INCIDENT

NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)

SS 8572 (Rev. 12/02)

DEFINITIONS AND INSTRUCTIONS ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY- District Attorney's Office; YELLOW COPY-Reporting Party

STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT CHILD ABUSE

NOTE: RETAIN IN EMPLOYEE/LICENSEE FILE

NAME

POSITION	FACILITY NUMBER

California law REQUIRES certain persons to report known or suspected child abuse. As a licensee or an employee at a licensed facility or a child care institution, YOU are one of those persons - a "mandated reporter."

PERSONS WHO ARE REQUIRED TO REPORT ABUSE

Mandated reporters include a licensee, an administrator, or an employee of a licensed community care or child day care facility. [Penal Code ("PC") § 11165.7(a)(10)] Mandated reporters also include an employee of a child care institution, including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities. [PC § 11165.7(a)(14)] No supervisor or administrator may impede or inhibit an individual's reporting duties or subject the mandated reporter to any sanction for making the report. [PC § 11166(h)]

WHEN REPORTING ABUSE IS REQUIRED

A mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has knowledge of or observes a person under the age of 18 years whom he or she knows or reasonably suspects has been the victim of child abuse or neglect must report the suspected incident. The reporter must contact a designated agency immediately or as soon as practically possible by telephone, and shall prepare and send a written report within 36 hours of receiving the information concerning the incident. [PC § 11166(a)]

ABUSE THAT MUST BE REPORTED

Physical injury inflicted by other than accidental means on a child. [PC § 11165.6]

Sexual abuse meaning sexual assault or sexual exploitation of a child. [PC § 11165.1]

Neglect meaning the negligent treatment, lack of treatment, or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. [PC § 11165.2]

Willful harming or injuring or endangering a child meaning a situation in which any person inflicts, or willfully causes or permits a child to suffer, unjustifiable physical pain or mental suffering, or causes or permits a child be placed in a situation in which the child or child's health is endangered. [PC § 11165.3]

Unlawful corporal punishment or injury willfully inflicted upon a child and resulting in a traumatic condition. [PC § 11165.4]

WHERE TO CALL IN AND SEND THE WRITTEN ABUSE REPORT

Reports of suspected child abuse or neglect must be made to any police department or sheriff's department (not including a school district police or security department), county probation department, if designated by the county to receive mandated reports, or the county welfare department. [PC § 11165.9] The written report must include the information described in Penal Code section 11167(a) and may be submitted on form SS 8572.

IMMUNITY AND CONFIDENTIALITY OF REPORTER AND OF ABUSE REPORTS

Persons legally mandated to report suspected child abuse have immunity from criminal or civil liability for reporting as required or authorized by law. [PC § 11172(a)] The identity of a mandated reporter is confidential and disclosed only among agencies receiving or investigating reports, and other designated agencies. [PC § 11167(d)(1)] Reports are confidential and may be disclosed only to specified persons and agencies. Any violation of confidentiality is a misdemeanor punishable by imprisonment, fine, or both. [PC § 11167.5(a)-(b)]

PENALTY FOR FAILURE TO REPORT ABUSE

A mandated reporter who fails to make a required report is guilty of a **misdemeanor** punishable by up to six months in jail, a fine of $1000, or both. [PC § 11166(b)]

COPY OF THE LAW

Prior to my employment in a licensed community care or child day care facility, or child care institution, my employer provided me with a copy of Penal Code sections 11165.7, 11166, and 11167. [PC § 11166.5(a)]

ACKNOWLEDGMENT OF RESPONSIBLITY

I, _____, have knowledge of my responsibility to report known or suspected child abuse in compliance with Penal Code section 11166. [PC § 11166.5(a)]

SIGNATURE	DATE

PCP	Page 1 of 5
Section : Personnel	
POLICY AND PROCEDURE: Personnel Training Elder Abuse Reporting	Approved Date:_____ Approved By :_____ Effective Date:_____ Revised Date:_____ Revised Date:_____

POLICY:

Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment, has observed, suspects, or has knowledge of an incident that reasonably appears to be physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect), or is told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, isolation, financial abuse, abduction, or neglect, shall report the known or suspected instance of abuse to the appropriate agency. (Welfare and Institutions Code§ 15630 [b]).

PROCEDURE:

I. Reporting

A. Reports must be made both by telephone and in writing

1. A telephone report must be made immediately or as soon as practically possible
2. A written report is to be made within two working days using the SOC 341, "Report of Suspected Elder/Dependent Adult Abuse" form (see attachment)
   - To request a supply of SOC 341s, send a letter or fax to:

     Department of Social Services Warehouse
     P.O. Box 980788
     West Sacramento, Ca 95798-078
     Fax: 916-371-3518
3. All of the following types of abuse must be reported:
   - Physical abuse (including sexual abuse)
   - Abandonment
   - Isolation
   - Abduction
   - Financial abuse
   - Neglect (including self-neglect)
4. Report to the local law enforcement agency or to Adult Protective Services when abuse, neglect or self-neglect is suspected to have occurred in the community
5. Report to the local law enforcement agency or to Long Term Care Ombudsman when the abuse or neglect is suspected to have occurred in a long-term care facility

6. Failure to make a mandated report is a misdemeanor, punishable by imprisonment in the county jail for up to six months, or a fine of up to $1,000 or both
7. Any mandated reporter who willfully fails to report abuse of an elder or a dependent adult, where the abuse results in death or great bodily injury, may be punished by up to one year in the county jail, or by a fine of up to $5,000, or y both imprisonment and fine
8. A single report may be made when two or more persons have knowledge of a suspected instance of abuse

II. **Exceptions to Reporting Requirement**

A. There are exceptions to the requirement to report:

1. Reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred
2. The elder or the dependent adult has been diagnosed with a mental Illness or dementia, or is the subject of a court-ordered conservatorship because of mental illness or dementia
3. The reporter reasonably believes that the abuse did not occur

Ill. **Possible Indicators of Abuse or Neglect**

A. Physical Signs
1. Injury that has not been cared for properly
2. Injury that is inconsistent with explanation for cause
3. Pain from touching
4. Cuts puncture wounds, burn, bruises, and welts
5. Dehydration or malnutrition without illness-related cause
6. Poor coloration
7. Sunken eyes or cheeks
8. Inappropriate administration of medication
9. Soiled clothing or bed
10. Frequent use of hospital or health care/doctor shopping
11. Lack of necessities such as food, water, or utilities
12. Lack of personal effects, pleasant living environment, and personal items
13. Forced isolation

B. Behavioral Signs
1. Fear
2. Anxiety, agitation
3. Anger
4. Isolation, withdrawal
5. Depression

6. Non-responsiveness, resignation, ambivalence
7. Contradictory statements, implausible stories
8. Hesitation to talk openly
9. Confusion or disorientation

C. Signs by Caregiver
1. Prevents elder from speaking to or seeing visitors
2. Anger, indifference, aggressive behavior toward elder
3. History of substance abuse, mental illness, criminal behavior, or family violence
4. Lack of affection toward elder
5. Flirtation or coyness as possible indicator of inappropriate sexual relationships
6. Conflicting accounts of incidents
7. Withholds affection

IV. Definitions

A. Abandonment: The desertion or willful forsaking of an elder or dependent Adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide are or custody

B. Abduction: The removal from California, and/or the restraint from returning to California, of an elder/dependent adult who does not have the capacity to consent to such removal or restraint, as well as the removal or restraint of any conservative without the consent of the conservator or court

C. Abuse of an elder or a dependent adult: Physical abuse (including sexual abuse), neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or mental suffering, or the deprivation by a care custodian of goods or services that is necessary to avoid harm or mental suffering

D. Dependent adult: Any person between the ages of 18 and 64 years, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights. This includes, but is not limited to, persons who have physical or developmental disabilities. It also includes those whose physical or mental abilities have diminished because of age as well as any 10 to 64 year old who is admitted as an inpatient to a 24-hour health facility

E. Elder: Any person who is 65 years of age or older

F. Financial Abuse: A situation in which a person or entity takes, secretes, appropriates or retains the real or personal property of an elder or dependent adult to a wrongful use, or with intent to defraud, or both, OR assists another in this process. The person or entity is deemed to have committed financial abuse if such actions were taken, in bad faith. A person or entity is considered to have acted in bad faith if he/they knew or should have known that the elder or dependent adult had the right to have the property transferred or made readily available to him/her or to his/her representative

G. Goods and services: includes but is not limited to all of the following:
- The provision of medical care for physical and mental health needs
- Assistance in personal hygiene
- Adequate clothing
- Adequately heated and ventilated shelter
- Protection from health and safety hazards
- Protection from malnutrition, under circumstances where the results include, but are not limited to, malnutrition and deprivation of necessities or physical punishment
- Transportation and assistance necessary to secure the above goods and services

H. Isolation: any of the following unless performed pursuant to a medical care plan, or unless performed in response to a reasonably perceived threat of danger to property or physical safety:
- Preventing the elder or dependent adult from receiving his/her mail or telephone calls
- Telling a caller or visitor that the elder or dependent adult does not wish to see/speak to the person, when this is contrary to the elder or dependent adult's wishes, regardless of whether he/she is mentally competent
- False imprisonment, as defined in California Penal Code, Section 236
- Physical restraint of the elder or dependent adult to prevent contact with family, friends, or concerned persons

I. Mental suffering: fear, agitation, confusion, severe depression, or other forms of serious emotional distress that is brought about by threats, harassment, or other forms of intimidating behavior

J. Neglect: the negligent failure of any person having care or custody of an elder or dependent adult to exercise that degree of care that a reasonable person in a like position would exercise, including, but not limited to:
- Failure to assist in personal hygiene or in the provision of food, clothing, or shelter
- Failure to provide medical care for physical and mental health needs

- Failure to protect from health and safety hazards
- Failure to prevent malnutrition or dehydration

K. Physical abuse: assault, battery, assault with a deadly weapon or with force likely to produce great bodily injury, unreasonable physical constraint, prolonged or continual deprivation of food or water, sexual assault or battery or rape (including spousal rape, incest, sodomy, oral copulation, or penetration by a foreign object). Physical abuse also includes the use of physical or chemical restraint or psychotropic medication either for punishment or for a period or purpose beyond which the restraint or medication was ordered by the attending, licensed physician

L. Reasonable suspicion: an objectively reasonable suspicion of abuse that a person should entertain, based upon the facts, and drawing upon the person's training and experience

M. Self-neglect: failure of the elder or dependent adult to exercise a reasonable degree of care in providing for his/her own needs in such areas as personal hygiene, food, clothing, shelter, medical and mental health care, or avoiding health and safety hazards, malnutrition or dehydration, when that failure is due to ignorance, illiteracy, incompetence, mental limitation, substance abuse or poor health

CONFIDENTIAL REPORT - NOT SUBJECT TO PUBLIC DISCLOSURE

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

DATE COMPLETED

TO BE COMPLETED BY REPORTING PARTY. PLEASE PRINT OR TYPE. SEE GENERAL INSTRUCTIONS.

A. VICTIM ☐ Check box if victim consents to disclosure of information (Ombudsman use only - WIC 15636(a))

NAME (LAST NAME, FIRST NAME) | AGE | DATE OF BIRTH

SSN | GENDER ☐ M ☐ F | ETHNICITY | LANGUAGE (✔ CHECK ONE) ☐ NON-VERBAL ☐ ENGLISH ☐ OTHER (*SPECIFY*)

ADDRESS (IF FACILITY, INCLUDE NAME AND NOTIFY OMBUDSMAN) | CITY | ZIP CODE | TELEPHONE ( )

PRESENT LOCATION (IF DIFFERENT FROM ABOVE) | CITY | ZIP CODE | TELEPHONE ( )

☐ ELDERLY (65+) ☐ DEVELOPMENTALLY DISABLED ☐ MENTALLY ILL/DISABLED ☐ LIVES ALONE
☐ PHYSICALLY DISABLED ☐ UNKNOWN/OTHER ☐ LIVES WITH OTHERS

B. SUSPECTED ABUSER ✔ *Check if* ☐ *Self-Neglect*

NAME OF SUSPECTED ABUSER

ADDRESS | CITY | ZIP CODE | TELEPHONE ( )

☐ CARE CUSTODIAN (type) _____ ☐ PARENT ☐ SON/DAUGHTER ☐ OTHER _____
☐ HEALTH PRACTITIONER (type) _____ ☐ SPOUSE ☐ OTHER RELATION _____

GENDER ☐ M ☐ F | ETHNICITY | AGE | D.O.B. | HEIGHT | WEIGHT | EYES | HAIR

C. REPORTING PARTY *Check appropriate box if reporting party waives confidentiality to:* ☐ ✔ All ☐ ✔ All but victim ☐ ✔ All but perpetrator

NAME | SIGNATURE | OCCUPATION | AGENCY/NAME OF BUSINESS

RELATION TO VICTIM/HOW ABUSE IS KNOWN | STREET | CITY | ZIP CODE | TELEPHONE ( )

E-MAIL ADDRESS

D. INCIDENT INFORMATION - Address where incident occurred

DATE/TIME OF INCIDENT(S)

PLACE OF INCIDENT (✔ CHECK ONE)
☐ OWN HOME ☐ COMMUNITY CARE FACILITY ☐ HOSPITAL/ACUTE CARE HOSPITAL
☐ HOME OF ANOTHER ☐ NURSING FACILITY/SWING BED ☐ OTHER (Specify)

E. REPORTED TYPES OF ABUSE (✔ CHECK ALL THAT APPLY)

1. PERPETRATED BY OTHERS (WIC 15610.07 & 15610.63)

a. ☐ PHYSICAL (e.g. assault/battery, constraint or deprivation, chemical restraint, over/under medication)
b. ☐ SEXUAL
c. ☐ FINANCIAL
d. ☐ NEGLECT (including Deprivation of Goods and Services by a Care Custodian
e. ☐ ABANDONMENT
f. ☐ ISOLATION
g. ☐ ABDUCTION
h. ☐ PSYCHOLOGICAL/MENTAL
i. ☐ OTHER _____

2. SELF-NEGLECT (WIC 15610.57(b)(5))

a. ☐ PHYSICAL CARE (e.g. personal hygiene, food, clothing, shelter)
b. ☐ MEDICAL CARE (e.g. physical and mental health needs)
c. ☐ HEALTH and SAFETY HAZARDS (e.g. risk of suicide, unsafe environment)
d. ☐ MALNUTRITION/DEHYDRATION
e. ☐ FINANCIAL SELF-NEGLECT (e.g. inability to manage one's own personal finances)
f. ☐ OTHER _____

ABUSE RESULTED IN (✔ CHECK ALL THAT APPLY)

☐ NO PHYSICAL INJURY ☐ MINOR MEDICAL CARE ☐ HOSPITALIZATION ☐ CARE PROVIDER REQUIRED
☐ DEATH ☐ MENTAL SUFFERING ☐ SERIOUS BODILY INJURY* ☐ OTHER (SPECIFY) _____
☐ UNKNOWN

F. REPORTER'S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. DOES ALLEGED PERPETRATOR STILL HAVE ACCESS TO THE VICTIM? DOES THE ALLEGATION INVOLVE A SERIOUS BODILY INJURY (see definition in section "Reporting Responsibilities and Time Frames" within the General Instructions)? PROVIDE ANY KNOWN TIME FRAME (2 days, 1 week, ongoing, etc.). *LIST ANY POTENTIAL DANGER FOR INVESTIGATOR (animals, weapons, communicable diseases, etc.).*

☐ ✔ CHECK IF MEDICAL, FINANCIAL (ACCOUNT INFORMATION, ETC.), PHOTOGRAPHS, OR OTHER SUPPLEMENTAL INFORMATION IS ATTACHED.

G. OTHER PERSON BELIEVED TO HAVE KNOWLEDGE OF ABUSE *(family, significant others, neighbors, medical providers, agencies involved, etc.)*

NAME	RELATIONSHIP
ADDRESS	TELEPHONE
	( )

H. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM'S CARE *(If unknown, list contact person)*

NAME	IF CONTACT PERSON ONLY ✔ CHECK ☐		RELATIONSHIP
ADDRESS	CITY	ZIP CODE	TELEPHONE
			( )

I. TELEPHONE REPORT MADE TO ☐ APS ☐ Law Enforcement ☐ Local Ombudsman ☐ Calif. Dept. of State Hospitals ☐ Calif. Dept. of Developmental Services

NAME OF OFFICIAL CONTACTED BY PHONE	TELEPHONE	DATE/TIME
	( )	

J. WRITTEN REPORT **Enter information about the agencies receiving this report. If the abuse occurred in a LTC facility and resulted in Serious Bodily Injury*, please refer to "Reporting Responsibilities and Time Frames" in the General Instructions. Do not submit report to California Department of Social Services Adult Programs Division.**

AGENCY NAME	ADDRESS OR FAX		
		☐ Date Mailed	☐ Date Faxed
AGENCY NAME	ADDRESS OR FAX		
		☐ Date Mailed	☐ Date Faxed
AGENCY NAME	ADDRESS OR FAX		
		☐ Date Mailed	☐ Date Faxed

K. RECEIVING AGENCY USE ONLY ☐ Telephone Report ☐ Written Report

1. Report Received by	Date/Time

2. Assigned ☐ Immediate Response ☐ Ten-Day Response ☐ No Initial Response (NIR)
☐ Not APS ☐ Not Ombudsman ☐ No Ten-Day (NTD)

Approved by Assigned to (optional)

3. Cross-Reported to ☐ CDPH-Licensing & Cert.; ☐ CDSS-CCL; ☐ Local Ombudsman; ☐ Bureau of Medi-Cal Fraud & Elder Abuse; ☐ Calif. Dept. of State Hospitals; ☐ Law Enforcement; ☐ Professional Licensing Board; ☐ Calif. Dept. of Developmental Services; ☐ APS; ☐ Other (Specify) Date of Cross-Report

4. APS/Ombudsman/Law Enforcement Case File Number

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE GENERAL INSTRUCTIONS

PURPOSE OF FORM

This form, as adopted by the California Department of Social Services (CDSS), is required under Welfare and Institutions Code (WIC) Sections 15630 and 15658(a)(1). This form documents the information given by the reporting party on the suspected incident of abuse or neglect of an elder or dependent adult. **Abuse** means any treatment with resulting physical harm, pain, or mental suffering or the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering. **Neglect** means the negligent failure of an elder or dependent adult or of any person having the care or custody of an elder or a dependent adult to exercise that degree of self-care or care that a reasonable person in a like position would exercise. **Elder** means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). **Dependent Adult** means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age (WIC Section 15610.23). Dependent adult includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility (defined in the Health and Safety Code Sections 1250, 1250.2, and 1250.3).

COMPLETION OF THE FORM

1. This form may be used by the receiving agency to record information through a telephone report of suspected dependent adult/elder abuse.
2. If any item of information is unknown, enter "unknown."
3. Item A: Check box to indicate if the victim waives confidentiality.
4. Item C: Check box if the reporting party waives confidentiality. Please note that mandated reporters are required to disclose their names, however, non-mandated reporters may report anonymously.

REPORTING RESPONSIBILITIES AND TIME FRAMES:

Any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse or neglect, or reasonably suspects that abuse or neglect has occurred, shall complete this form for each report of known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect (self-neglect), isolation, and abandonment) involving an elder or dependent adult.

*__Serious bodily injury__ means an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation (WIC Section 15610.67).

Reporting shall be completed as follows:

- If the abuse occurred in a Long-Term Care (LTC) facility (as defined in WIC Section 15610.47) and resulted in serious bodily injury, report by telephone to the local law enforcement agency immediately and no later than two (2) hours after observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local Long-Term Care Ombudsman Program (LTCOP), and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within two (2) hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, was physical abuse, but did not result in serious bodily injury, report by telephone to the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local LTCOP, and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, was physical abuse, did not result in serious bodily injury, and was perpetrated by a resident with a physician's diagnosis of dementia, report by telephone to the local law enforcement agency or the local LTCOP, immediately or as soon as practicably possible. Follow by sending the written report to the LTCOP or the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, was abuse other than physical abuse, report by telephone to the LTCOP or the law enforcement agency immediately or as soon as practicably possible. Follow by sending the written report to the local law enforcement agency or the LTCOP within two working days.

- If the abuse occurred in a state mental hospital or a state developmental center, mandated reporters shall report by telephone or through a confidential Internet reporting tool (established in WIC Section 15658) immediately or as soon as practicably possible and submit the report within two (2) working days of making the telephone report to the responsible agency as identified below:

    - If the abuse occurred in a State Mental Hospital, report to the local law enforcement agency or the California Department of State Hospitals.
    - If the abuse occurred in a State Developmental Center, report to the local law enforcement agency or to the California Department of Developmental Services.

- For all other abuse, mandated reporters shall report by telephone or through a confidential Internet reporting tool to the adult protective services agency or the local law enforcement agency immediately or as soon as practicably possible. If reported by telephone, a written or an Internet report shall be sent to adult protective services or law enforcement within two working days.

REPORTING PARTY DEFINITIONS

Mandated Reporter (WIC Section 15630 (a)) Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter.

Care Custodian (WIC Section 15610.17) means an administrator or an employee of any of the following public or private facilities or agencies, or persons providing are or services for elders or dependent adults, including members of the support staff and maintenance staff: (a) Twenty-four hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code; (b) Clinics; (c) Home health agencies; (d) Agencies providing publicly funded in-home supportive services, nutrition services, or other home and community-based support services; (e) Adult day health care centers and adult day care; (f) Secondary schools that serve 18- to 22-year-old dependent adults and postsecondary educational institutions that serve dependent adults or elders; (g) Independent living centers; (h) Camps; (i) Alzheimer's Disease Day Care Resource Centers; (j) Community care facilities, as defined in Section 1502 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code; (k) Respite care facilities; (l) Foster homes; (m) Vocational rehabilitation facilities and work activity centers; (n) Designated area agencies on aging; (o) Regional centers for persons with developmental disabilities; (p) State Department of Social Services and State Department of Health Services licensing divisions; (q) County welfare departments; (r) Offices of patients' rights advocates and clients' rights advocates, including attorneys; (s) The Office of the State Long-Term Care Ombudsman; (t) Offices of public conservators, public guardians, and court investigators; (u) Any protection or advocacy agency or entity that is designated by the Governor to fulfill the requirements and assurances of the following: (1) The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, contained in Chapter 144 (commencing with Section 15001) of Title 42 of the United States Code, for protection and advocacy of the rights of persons with developmental disabilities; or (2) The Protection and Advocacy for the Mentally Ill Individuals Act of 1986, as amended, contained in Chapter 114 (commencing with Section 10801) of Title 42 of the United States Code, for the protection and advocacy of the rights of persons with mental illness; (v) Humane societies and animal control agencies; (w) Fire departments; (x) Offices of environmental health and building code enforcement; or (y) Any other protective, public, sectarian, mental health, or private assistance or advocacy agency or person providing health services or social services to elders or dependent adults.

Health Practitioner (WIC Section 15610.37) means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family, and child counselor trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage, family, and child counselor intern registered under Section 4980.44 of the Business and Professions Code, state or county public health or social service employee who treats an elder or a dependent adult for any condition, or a coroner.

Any officer and/or employee of a financial institution is a mandated reporter of suspected financial abuse and shall report suspected financial abuse of an elder or dependent adult on form SOC 342, “Report of Suspected Dependent Adult/Elder Financial Abuse”.

MULTIPLE REPORTERS

When two or more mandated reporters are jointly knowledgeable of a suspected instance of abuse of a dependent adult or elder, and when there is agreement among them, the telephone report may be made by one member of the group. Also, a single written report may be completed by that member of the group. Any person of that group, who believes the report was not submitted, shall submit the report.

IDENTITY OF THE REPORTER

The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only among APS agencies, local law enforcement agencies, LTCOPs, California State Attorney General Bureau of Medi-Cal Fraud and Elder Abuse, licensing agencies or their counsel, Department of Consumer Affairs Investigators (who investigate elder and dependent adult abuse), the county District Attorney, the Probate Court, and the Public Guardian. Confidentiality may be waived by the reporter or by court order.

FAILURE TO REPORT

Failure to report by mandated reporters (as defined under "Reporting Party Definitions") any suspected incidents of physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect) of an elder or a dependent adult is a misdemeanor, punishable by not more than six months in the county jail, or by a fine of not more than $1,000, or by both imprisonment and fine. Any mandated reporter who willfully fails to report abuse of an elder or a dependent adult, where the abuse results in death or great bodily injury, may be punished by up to one year in the county jail, or by a fine of up to $5,000, or by both imprisonment and fine (WIC Section 15630(h)).

Officers or employees of financial institutions are mandated reporters of financial abuse (effective January 1, 2007). These mandated reporters who fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $1,000. Individuals who willfully fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $5,000. These civil penalties shall be paid by the financial institution, which is the employer of the mandated reporter, to the party bringing the action.

EXCEPTIONS TO REPORTING

Per WIC Section 15630(b)(3)(A), a mandated reporter who is a physician and surgeon, a registered nurse, or a psychotherapist, as defined in Section 1010 of the Evidence Code, shall not be required to report a suspected incident of abuse where all of the following conditions exist:

(1) The mandated reporter has been told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect).
(2) The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.
(3) The elder or the dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia.
(4) In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist, as defined in Section 1010 of the Evidence Code, reasonably believes that the abuse did not occur.

DISTRIBUTION OF SOC 341 COPIES

Mandated reporter: After making the telephone report to the appropriate agency or agencies, the reporter shall send the written report to the designated agencies (as defined under "Reporting Responsibilities and Time Frames"); and keep one copy for the reporter's file.

Receiving agency: Place the original copy in the case file. Send a copy to a cross-reporting agency, if applicable.
DO NOT SEND A COPY TO THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES ADULT PROGRAMS DIVISION.

PCP:	Page 1 of 2
SECTION: Personnel	
POLICY AND PROCEDURE: Personnel Training: Domestic Violence Reporting	Approved date: _____ Approved By: _____ Effective date: _____ Revised date: _____ Revised date:_____

POLICY:

Health care providers who provide medical services for a physical condition to a patient whom he or she knows or reasonably suspects of suffering from injuries resulting from a firearm or assaultive or abusive conduct, are required to make a report (Penal Code Section 11160 et. seq.).

PROCEDURE:

I. Reporting

A. Reports must be made both by telephone and in writing to a local law enforcement agency

1. A telephone report must be made immediately or as soon as practically possible
2. A written report is to be made within two working days of receiving the Information using OCJP 920: Suspicious Injury Report Form (see attachment)
3. The report must include the following:
   - Name of the injured person, if known
   - The injured person's whereabouts
   - Character and extent of the person's injuries
   - The identity of the person who allegedly inflicted the injury
4. Failure to make a mandated report is a misdemeanor, punishable by imprisonment in the county jail for up to six months, or a fine of up to $1,000 or both
5. Check with the local law enforcement agency of where to report if the patient was injured in another county
6. If the battered patient is a minor then the Child Abuse and Neglect Reporting Act applies. (see Child Abuse Reporting policy and procedure)

II. Medical Record

A. The law (P.C. § 11161 [b]) recommends that the medical record include the following:
   - Any comments by the injured person regarding past domestic violence or regarding the name of any person suspected of inflicting the injury
   - A map of the injured person's body showing and identifying injuries and bruises

- A copy of the reporting form

III. Important Considerations

A. Sensitivity and awareness

- Reassure patient he/she is not alone and does not deserve to be treated this way
- Be careful not to imply patient is to blame
- Patients may be scared of seeking care because they do not want police involvement
- Some patients may fear reporting for other reasons (i.e. immigration status)
- There are many barriers to leaving an abusive situation (i.e. threats from the batterer, fear of financial instability, failure of police and others to effectively intervene, hope the relationship can work, feel responsible for the battering, may be embarrassed, humiliated and degraded about the abuse)

B. Patient Safety

- Address directly the risk of retaliation by the batterer and discuss how the patient might protect her/himself from further abuse
- Discuss the patient's short-term option and plan, including whether the patient can safely return home
- Indicate on the reporting form any special concerns regarding how the report should be handled to maximize patient safety

C. Referral

- Provide. Patient with referrals to domestic violence services
- Assist the patient in calling a domestic crisis line if willing

D. Special Considerations

- Patients who plan to leave with their children (applies to children for whom the abusive partner is the biological or adoptive parent) should call one of the shelter lines to learn how to file a "Good Cause Report" which can protect them from kidnapping charges

IV. Definitions

A. Assaultive or abusive conduct is defined to include a list of 24 criminal offenses, among which are murder, manslaughter, torture, battery, sexual battery, incest, assault with a deadly weapon, rape, spousal rape, abuse of spouse or cohabitant, sodomy, oral copulation and an attempt to commit any of these crimes

CALIFORNIA EMERGENCY MANAGEMENT AGENCY

SUSPICIOUS INJURY REPORT

CalEMA 2-920 (4/1/09)

STATE OF CALIFORNIA

INFORMATION DISCLOSURE

This form is for law enforcement use only and is confidential in accordance with Section 11163.2 of the Penal Code. This form shall not be disclosed except by local law enforcement agencies to those involved in the investigation of the report or the enforcement of a criminal law implicated by this report. In no case shall the person identified as a suspect be allowed access to the injured person's whereabouts. The person making this report shall not be required to disclose his/her identity to their employer (PC 11160).

Part A: PATIENT WITH SUSPICIOUS INJURY

1. PATIENT'S NAME (Last, First, Middle)	2. BIRTH DATE	3. GENDER ☐ M ☐ F	4. SAFE PHONE NUMBER ( )

5. PATIENT'S RESIDING ADDRESS (Number and Street / Apt – **NO P.O. Box)** City State Zip

6. PATIENT SPEAKS ENGLISH ☐ Y ☐ N – Identify language spoken: _____	7. DATE AND TIME OF INJURY Date: Time: ☐ am ☐ pm ☐ Unknown

8. LOCATION / ADDRESS WHERE INJURY OCCURRED, IF AVAILABLE – Check here if unknown: ☐

9. PATIENT'S COMMENTS ABOUT THE INCIDENT – Include any identifying information about the person the patient alleges caused the injury and the names of any persons who may know about the incident. ☐ ADDITIONAL PAGES ATTACHED

10. NAME OF SUSPECT – If identified by the patient	11. RELATIONSHIP TO PATIENT, IF ANY

12. SUSPICIOUS INJURY DESCRIPTION – Include a brief description of physical findings and the final diagnosis. ☐ ADDITIONAL PAGES ATTACHED

Part B: REQUIRED – AGENCIES RECEIVING PHONE AND WRITTEN REPORTS

13. LAW ENFORCEMENT AGENCY NOTIFIED BY PHONE (Mandated by PC 11160)	14. DATE AND TIME REPORTED Date: Time: ☐ am ☐ pm

15. NAME OF PERSON RECEIVING PHONE REPORT (First and Last)	16. JOB TITLE	17. PHONE NUMBER ( )

18. LAW ENFORCEMENT AGENCY RECEIVING WRITTEN REPORT (Mandated by PC 11160)	19. AGENCY INCIDENT NUMBER

Part C: PERSON FILING REPORT

20. EMPLOYER'S NAME	21. PHONE NUMBER ( )

22. EMPLOYER'S ADDRESS (Number and Street) City State Zip

23. NAME OF HEALTH PRACTITIONER (First and Last)	24. JOB TITLE

25. HEALTH PRACTITIONER'S SIGNATURE:	26. DATE SIGNED:

CALIFORNIA EMERGENCY MANAGEMENT AGENCY

SUSPICIOUS INJURY REPORT

CalEMA 2-920 (rev 4/09)

STATE OF CALIFORNIA

Instructions To The Health Practitioner

Penal Code Section 11160 *mandates* the following regarding suspicious injuries:

- Internal procedures established to facilitate reporting and apprise supervisors and administrators of reports shall be consistent with the reporting requirements of PC Section 11160. The internal procedures shall not require any employee who must make a report to disclose his or her identity to the employer.
- Report suspicious injuries to your local law enforcement agency by telephone **immediately**, or as soon as practically possible.
- Submit the required completed written report to your local law enforcement agency *within two working days of discovering a suspicious injury,* whether or not:
  1. The person has expired;
  2. The injury was a factor contributing to the person's death; or
  3. Evidence of the conduct of the perpetrator is discovered during an autopsy.
- Use this standard form or a form, developed and adopted by another state agency, that otherwise fulfills the requirements of this form, (see "Exceptions to using this form" below).
- Two or more health practitioners with knowledge of a suspicious injury may mutually select a team member to make the telephone report and one written report signed by the selected team member. A team member who knows that the selected team member has not made the telephone call or submitted the written report shall make the report(s).
- No supervisor or administrator shall impede or inhibit the required reporting duties, and no person making a report pursuant to this section shall be subject to any sanction for making the report.

Exceptions To Using This Form

Other state reporting mandates pre-empt the use of this form to report suspicious injuries, as follows:

Incident	Form	Source of Form
Physical Child Abuse	SS 8572	Call California Department of Justice at (916) 227-3285.
Dependent Adult / Elder Abuse	SOC 341	Online: http://www.dss.cahwnet.gov/pdf/SOC341.pdf or contact your local County Adult Protective Services Dept.
Sexual Assault – Adult*	CalEMA 2-923*	Online: www.CalEMA.ca.gov under Plans and Publications or call Cal EMA at (916) 324-9100.
Sexual Assault – Child*	CalEMA 2-925*	

*Use these forms to conduct a forensic examination of the victim. Otherwise, use this Suspicious Injury Report form.

Definitions

Health Practitioner – Provides medical services to a patient for a physical condition that he/she reasonably suspects is a suspicious injury as listed below, and is employed in a health facility, clinic, physician's office, local or state public health department, or a clinic or other type of facility operated by a local or state public health department.

Suspicious Injury – Includes any wound or other physical injury that either was:

- Inflicted by the injured person's own act or by another where the injury is by means of a firearm, OR
- Is suspected to be the result of *assaultive or abusive conduct* inflicted upon the injured person.

Injury – Shall not include any psychological or physical condition brought about solely through the voluntary administration of a narcotic or restricted dangerous drug.

Assaultive / Abusive Conduct – includes committing, or an attempt to commit, any of the following Penal Code violations:

- Abuse of spouse or cohabitant
- Aggravated mayhem
- Administering controlled substances or anesthetic to aid in the commission of a felony
- Assault with a stun gun or taser
- Assault with a deadly weapon, firearm, assault weapon or machine gun, or by means likely to produce great bodily injury
- Assault with intent to commit mayhem, rape, sodomy, or oral copulation
- Battery
- Child abuse or endangerment (including Statutory Rape)
- Elder abuse
- Incest
- Lewd and lascivious acts with a child
- Murder
- Manslaughter
- Mayhem
- Oral copulation
- Procuring any female to have sex with another man
- Rape
- Sexual battery
- Sexual penetration
- Sodomy
- Spousal rape
- Throwing any vitriol, corrosive acid, or caustic chemical with intent to injure or disfigure
- Torture CAL

PCP	Page 1 of 2
Section : Personnel	
POLICIY AND PROCEDURE: Personnel Training Informed Consent and Human Sterilization Consent	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:_____

POLICY:
Site personnel receive training and/or information on member rights that include informed consent and human sterilization consent.

PROCEDURE:

1. Written Member Rights should be available at the office site. Staff should be able to locate the written Member Rights list and explain how to use the information.

2. Staff trainings regarding member rights may be part of office staff education documented in:
   - Informal or formal in-services
   - New staff orientation
   - External training courses

3. Topics included in the trainings must include:
   a. Informed Consent for Human Sterilization

      Patients shall be informed about any proposed treatment or procedure that includes medically significant risks, alternate courses of treatment or non- treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment. Documentation of this discussion and the signed consent shall be written and included in the member's medical record.

      Note: patient rights incorporate the requirements of the Joint Commission on Accreditation of Healthcare Organizations, Title 22, *California Code of Regulations, Section 70707 and Medicare Conditions of Participation.*

      Requirements include and are not limited to:

      - Conducted by physician or physician designee
      - Offered booklet published by the DHCS and copy of consent form must be given to the member.
      - Provided answers to any question the member may have.
      - Inform the member may withdraw or withhold consent to procedure at any time before the sterilization.

- Describe fully the available alternatives of family planning and birth control.
- Advise that the sterilization procedure is considered irreversible.
- Explain fully the description of discomforts and risks and benefits of the procedure.
- Utilize the PM330 sterilization consent form.

>Forms may be ordered directly from the DHCS by placing a request to:

Department of Health Care Services Warehouse
1037 North Market Blvd, Suite 9
Sacramento, Ca 95834
Fax: 916-928-1326

Attachments:
Informed Consent and Human Sterilization

State of California -- Health and Human Services Agency

CONSENT FORM
PM 330

Department of Health Services

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from

_____ . When I first asked for
(doctor or clinic)

the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a

_____ .
(Name of procedure)

The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on ____/____/____ .
Mo Day Yr

I, _____
Last

_____ _____
First *M. I.*

hereby consent of my own free will to be sterilized by

_____ by a
(Doctor's name)

method called _____ .
(Name of procedure)

My consent expires **180 days** from the date of my **signature below**.

I also consent to the release of this form and other medical records about the operation to:

- **Representatives of the Department of Health and Human Services.**
- **Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.**

I have received a copy of this form.

_____ *Date:* ____/____/____
Signature of individual to be sterilized *Mo Day Yr*

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent

form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ *Date:* ____/____/____
Signature of Interpreter *Mo Day Yr*

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the
(Name of Individual to be sterilized)

consent form, I explained to him/her the nature of the sterilization

operation _____, the fact that it
(Name of procedure)

is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at anytime and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____ *Date:* ____/____/____
Signature of person obtaining consent *Mo Day Yr*

_____
Name of Facility where patient was counseled

_____
Address of Facility where patient was counseled *City* *State* *Zip Code*

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon

_____ on
(Name of individual to be sterilized)

____/____/____ *(Date of Sterilization),* I explained to him/her the nature of the
Mo Day Yr

sterilization operation _____ ,
(Name of procedure)

the fact that it is intended to be final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of Alternative Final Paragraphs**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery when the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. **Cross out the paragraph below which is not used.**

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (**check applicable box below and fill in information requested**.)

A ☐ Premature delivery date: ____/____/____ Individual's **expected date**
Mo Day Yr

of delivery: ____/____/____ (Must be 30 days from date of patient's signature).
Mo Day Yr

B ☐ Emergency abdominal surgery; describe circumstances: _____

_____

_____ *Date:* ____/____/____
Signature of Physician performing surgery *Mo Day Yr*

State of California -- Health and Human Services Agency

CONSENT FORM - PM 330

Department of Health Services

NOTA: NINGUNO DE LOS BENEFICIOS QUE RECIBO DE LOS PROGRAMAS O PROYECTOS SUBSIDIADOS CON FONDOS FEDERALES SE ME CANCELARÁ O SUSPENDERÁ EN CASO DE QUE YO DECIDA NO ESTERILIZARME.

■ CONSENTIMIENTO PARA ESTERILIZACIÓN ■

Declaro que he solicitado y obtenido información sobre esterilización de _____ (doctor o clinica). Al solicitar información se me dijo que yo soy la única persona que puede decidir esterilizarme o no y que estoy en mi derecho a negarme a ser esterilizado. Mi decisión de no esterilizarme no afectará mi derecho a recibir atención o tratamiento médico en el futuro, y tampoco dejaré de recibir ningún tipo de asistencia o beneficios que recibo actualmente de los programas subsidiados con fondos federales, tales como A.F.D.C. o Medicaid o de aquellos a los que pudiera tener derecho en el futuro.

ENTIENDO QUE LA ESTERILIZACIÓN DEBE SER CONSIDERADA **PERMANENTE** E **IRREVERSIBLE**. DECLARO QUE ES MI DECISIÓN EL NO QUERER VOLVER A EMBARAZARME, DAR A LUZ O SER PADRE NUEVAMENTE.

Declaro que se me ha informado acerca de la existencia de otros métodos anticonceptivos temporales que están a mi disposición y que me permitirían en un futuro tener hijos o ser padre nuevamente. Sin embargo, he rehusado estos metodos alternativos y he decidido esterilizarme.

Entiendo que se me va a esterilizar mediante un método conocido como:

_____ (Nombre del procedimiento)

Declaro que se me explicaron los malestares, riesgos y beneficios asociados con la operación, y que se respondió a todas mis preguntas satisfactoriamente.

Entiendo que la operación no se llevará a cabo hasta por lo menos treinta (30) días después de que firme este formulario, y que puedo cambiar de parecer en cualquier momento y decidir no esterilizarme. Si decido no esterilizarme, no dejaré de recibir ninguno de los beneficios o servicios médicios ofrecidos por los programas subsidiados con fondos federales.

Declaro tener al menos 21 años de edad y que nací en ____/____/____. *Mes Día Año*

Apellido

Nombre *I.*

por medio de la presente doy mi consentimiento libre y voluntario para ser esterilizado/a por _____ (Nombre del Doctor)

utilizando un método conocido como _____ (Nombre del procedimiento)

Mi consentimiento es válido sólo por un plazo de **180 días** a partir de la fecha en que firme este formulario como se muestra **abajo**.

Asimismo, doy mi consentimiento para que este formulario y otros expedientes médicos sobre la operación se den a conocer a:

- **Representantes del Departamento de Salud y Servicios Humanos.**
- **Empleados de los programas o proyectos que reciben fondos de dicho Departamento, pero únicamente para determinar si se cumplieron las leyes federales.**

He recibido copia de este formulario.

_____ *Fecha:* ____/____/____

Firma de la persona a se esterilizada *Mes Día Año*

■ DECLARACIÓN DEL INTÉRPRETE ■

Si se requiere de un intérprete para asistir a la persona que va a ser esterilizada: Declaro que he traducido la información y los consejos verbales que la persona que recibe este consentimiento le ha dado a la persona que va a ser esterilizada. También le he leído a la persona el contenido de este formulario de consentimiento en idioma _____ y le he explicado su contenido. A mi mejor saber y entender dicha persona ha comprendido las explicaciones que se le dieron.

_____ *Fecha:* ____/____/____

Firma del intérprete *Mes Día Año*

PM 330 (1/99) (Sp)

■ DECLARACION DE LA PERSONA QUE RECIBE EL CONSENTIMIENTO ■

Declaro que antes de que _____ (Nombre de la persona a ser esterilizada) firmara el formulario de consentimiento, le expliqué la naturaleza del método de esterilización conocido como _____ (Nombre del procedimiento). También le expliqué que dicha operación es final e irreversible, y le informe sobre los malestares, riesgos y beneficios asociados con dicho procedimiento.

Declaro que le he explicado a la persona a ser esterilizada acerca de la existencia de otros métodos anticonceptivos temporales y que a diferencia de estos, el método de esterilización es irreversible.

Declaro que le he informado a la persona a ser esterilizada que puede desistir en cualquier momento a este consentimiento y que esto no traerá como consecuencia la péridida de ningún servicio médico o beneficio subsidiado con fondos federales

Declaro que, a mi mejor saber y entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y parece estar en su sano juicio. Dicha persona, de forma voluntaria y con conocimiento de causa, ha solicitado ser esterilizada y parece entender la naturaleza y las consecuencias del procedimiento.

_____ *Fecha:* ____/____/____

Firma de quien recibe el consentimiento *Mes Día Año*

_____

Nombre del lugar donde el paciente recibió la información

_____

Dirección del lugar donde el paciente recibió la información Ciudad Estado Código Postal

■ DECLARACIÓN DEL MÉDICO ■

Declaro que poco aqntes de operar a _____ (Nombre de la persona a ser esterilizada) en ____/____/____ *(Fecha de esterilización),* le explique la naturaleza del metodo de esterilizacion conocido como _____ (Nombre del procedimiento), también le expliqué que este método es final e irreversible y le informé de los malestares, riegos y beneficios asociados con este procedimiento.

Mes Día Año

Declaro que le he explicado a la persona a ser esterilizada acerca de la existencia de otros métodos anticonceptivos temporales y que ha diferencia de estos, el método de esterilización es irreversible.

Declaro que le he informado a la persona a ser esterilizada que puede desistir en cualquier momento a este consentimiento y que esto no traerá como consecuencia la pérdida de ningún servicio médico o beneficios subsidado con fondos federales.

Declaro que, a mi mejor saber y entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y parece estar en su sano juicio. Dicha persona, de forma voluntaria y con conocimiento de causa, ha solicitado ser esterilizada y parece entender la naturaleza y las consecuencias del procedimiento.

(**Instrucciones para el Uso Alternativo de los Párrafos Finales:** Use el primer párrafo de abajo excepto en caso de parto prematuro o cirugía del abdomen de emergencia cuando la esterilización se lleve a cabo antes de que se cumplan treinta (30) días desde que la persona firmó este consentimiento. En dichos casos se debe usar el segundo párrafo. **Tachar el párrafo de abajo que no es usado.**

(1) Han pasado por lo menos trienta (30) días desde que la persona firmó este consentimiento y la fecha en que se realizó la esterilización.

(2) La esterilización se realizó en menos de 30 días, pero después de 72 horas desde que la persona firmó este consentimiento debido a lo siguiente: (**Marque la casilla correspondiente de abajo y escriba la información que se solicita.**)

A ☐ Fecha de parto prematuro: ____/____/____ **Fecha anticipada** del parto: ____/____/____ (Debe ser 30 dias a partir de la firma de la persona).

Mes Día Año

B ☐ Cirugía del abdomen de emergencia; describa las circunstancias: _____

_____ *Fecha:* ____/____/____

Firma del Doctor a cargo de la cirugía *Mes Día Año*

Example of PM-330 Sterilization Consent Form

State of California -- Health and Human Services Agency

CONSENT FORM
PM 330

Department of Health Services

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from (1) _____ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from A.F.D.C. or Medicaid that I am now g

I UNDER BE CONSIDERED **PERMANENT** D THAT I DO NOT WANT TO BEC THER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a (2) _____ (Name of procedu

Fields 2, 6, 13, & 20
Bilateral Tubal Ligation

Bilateral Tubal Ligation

The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.

Fields 4, 7, 12, & 18
Penny L. Sillen

I not be done until at least thirty days after I change my mind at any time and that my d I will not result in the withholding of any b federally funded programs.

I, at least 21 years of age and was born on (3) ___/___/___ Mo Day Yr.

(4) _____ Last

_____ First M. I.

hereby consent of my own free will to be sterilized by

(5) _____ by a (Doctor's na

method called (6) _____ (Name of procedure).

Bilateral Tubal Ligation

My consent expires **180 days** from the date of my **signature below.**

I also consent to the release of this form and other medical records about the operation to:

- **Representatives of the Department of Health and Human Services.**
- **Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.**

I have received a copy of this form.

(7) *Penny L. Sillen,* Date: (8) ___/___/___
Signature of individual to be sterilized Mo Day Yr

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in (9) _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ Date: (11) ___/___/___
Signature of Interpreter Mo Day Yr

PM 330 (1/99)

■ STATEMENT OF PERS NSENT ■

Before (12) *Penny L. Sillen,* signed the
(Name of individual to be sterilized)
consent form, I explained to zation
operation (13) **Bilateral Tubal Ligation** that it
(Name of procedure)
is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at anytime and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ Date: (15) ___/___/___
Signature of person obtaining consent Mo Day Yr

(16) _____
Name of Facility where patient was counseled

(17) _____
Address of Facility where patient was counseled City State Zip Code

■ PHYSICIAN'S STATEMENT ■

Shortly b n operation upon
(18) *Penny L. Sillen,* on
(Name of individual to be sterilized)
(19) ___/___/___ (Date of Sterilization), I explained to him/her the nature of the
Mo Day Yr
sterilization operation (20) **Bilateral Tubal Ligation**.
(Name of procedure)
the fact that it is intended to be final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/sh y Federal funds.

To the best of my t least 21 years old and d voluntarily requested to b d consequences of the proc

Fields 21 & 22
Cross off the Paragraph which DOES NOT APPLY

(Instructions for use of Alternative Final Paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery when the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. **Cross out the paragraph below which is not used.**

(21) (1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(22) (2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (**check applicable box below and fill in information requested.**)

Fields 27 & 28
Physician Signature & Date must be ON or AFTER Sterilization DATE

idual's **expected date**

of patient's signature).

nstances: _____

(27) *Marcus J. Welby M.D.* Date: (28) ___/___/___
Signature of Physician performing surgery Mo Day Yr

PM-330 *Sterilization Consent Form*
Tips & Reminders for Successful Billing

☑ **Name of procedure.** **Fields 2, 6, 13 and 20** require the name of the procedure. The name of the procedure must be present and must be **consistent** throughout the form and **must** match name of procedure on the claim.

☑ **Patient's name.** **Fields 4, 7, 12 and 18** require the name of the patient to be consistent throughout the form.

Tip: Use the name as reflected on the BIC or the name used when determining Family PACT eligibility.

☑ **Field 21 and 22 (Alternative Final Paragraphs).** The paragraph that does not apply **must be crossed out** (an **'X'** through the paragraph that does not apply is required).

(21) Paragraph one. **Do not** cross off paragraph one if the minimum waiting period of 30 days has been met.

(22) Paragraph two. **Do not** cross off paragraph two if the minimum waiting period of 30 days **has not** been met.

☑ **Physician's signature.** **Field 27** requires full signature of the Physician who has verified consent and who actually performed the operation.

☑ **Date.** **Field 28** must be present (month/day/year). Date must be on or after the sterilization date.

Note: These instructions must be followed **exactly** or the *Consent Form* will be returned and reimbursement delayed.

A completed PM 330 *Sterilization Consent Form* must accompany all claims directly related to the sterilization surgery. This requirement extends to all providers, attending physicians, surgeons, assistant surgeons, anesthesiologists and facilities.

The above tips are being provided to assist in the prevention of common RAD code denials:
105 – This service requires a valid sterilization consent form.
115 – Sterilization Consent Form is incomplete. A letter has been sent that indicates needed correction.

Provider Manual Reference – Part 2: *Sterilization* section

PCP	Page 1 of 2
Section: Personnel	
POLICY AND PROCEDURE: Personnel Training Minors Rights	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:_____

POLICY:
Provide medical services per California Law Family Code to protect minors' rights to sensitive services.

PROCEDURE:

Sensitive Services/Minors Rights

- Parental consent is not required for members under the age of 18 to access pregnancy-related services, including family planning.

**California Law Family Code Section 6925.

- A minor who is 12 years of age or older and who may have come into contact with an infectious, contagious, or communicable disease may consent to medical care related to the diagnosis or treatment of the disease, if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health officer, or is a related sexually transmitted disease, as may be determined by the State Director of Health Services.

  The minor's parents or guardian are not liable for payment for medical care provided pursuant to this section.

** *California Law Family Code Section 6926 (6920-6929).*

- A minor may consent to the minor's medical care or dental care if all of the following conditions are satisfied:

(1) The minor is 15 years of age or older.
(2) The minor is living separate and apart from the minor's parents or guardian, whether with or without the consent of a parent or guardian and regardless of the duration of the separate residence.
(3) The minor is managing the minor's own financial affairs, regardless of the source of the minor's income.

- The parents or guardian are not liable for medical care or dental care provided pursuant to this section.
- A physician and surgeon or dentist may, with or without the consent of the minor patient, advise the minor's parent or guardian of the treatment given or needed if the physician and surgeon or dentist has reason to know, on the basis of the

Information given by minor, the whereabouts of the parent or guardian.
** California Law Family Code section 6922 (6920-6929)

- Special precautions must be taken to ensure that communication regarding the medical information of a minor related to sensitive services is protected (i.e. letters and phone calls should NOT be directed to the home without the minor's authorization).

PCP	Page 1 of 2
Section: Personnel	
POLICY AND PROCEDURE: Personnel Training Prior Authorization/Referrals	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:_____

POLICY:
To ensure that referrals for specialty care and medical procedures are processed in a timely manner, the site will have a process for the timely processing of internal and external referrals, consultant reports and diagnostic test results.

PROCEDURE:
I. REFERRAL FORMS

A. The staff has an organized, timely referral system clearly evident for making and tracking referrals, physician review of reports, and providing and/or scheduling follow-up care.

- Appropriate referral forms shall be available at the Primary Care Physician site. The practitioner shall complete the referral form and attach all relevant medical information. Refer to the attached Health Plan specific referral forms.

B. Primary Care Physician offices are required to maintain a "Referral Tracking Log" or an appropriate tickler system. Refer to the referral tracking log attached.

- The PCP must ensure timely receipt of the specialist's report or medical procedure report. Reports must be in the patient's medical record within thirty (30) days from the date of the procedure or appointment. If the PCP site has not received the report within 30 days, the PCP/staff will contact the specialist or procedure site to request a copy of the report.

C. The PCP shall ensure that referral informational resources, i.e. Health Plan Specialty and Network Directory are readily available for use by site personnel.

The following elements should be included within the referral system:

- Patient Name
- Date of Referral
- Referral Type
- Appointment Date
- Appointment Kept or Failed

- Date Report Received
- Physician Follow-up/Documentation

D. Site staff should be able to demonstrate (e.g., "walk through") the office referral process from beginning to end.

Referral Log

Date Referral sent to IPA	Patient Name and/or Medical Record Number	Referred to: Specialist/Facility	Auth. Status & Date Approved/Denied/ Deferred	Date Patient Notified	Date of Appt/ Services	Kept or Failed Appt	Date Report Received Physician Followed up Documentation

Instructions: When the physician orders a procedure, test or consultation, enter the date, patient's name, the referred to office and the date of the appointment. When the report of the ordered services is received, enter the date received. If the report is not received within 2 weeks of the scheduled date of the ordered service, call the provider of the service to inquire about the results report and document the call(s). Record results of actions taken to obtain report

PCP	Page 1 of 2
Section: Office Management	
POLICY AND PROCEDURE : Member Grievances/Complaints	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:_____

POLICY:

The site has an established process for member grievances and complaints.

- A "grievance" is defined as any written or oral expression of dissatisfaction that involves coverage dispute, healthcare medical necessity, experimental or investigational treatment. The health plan does not delegate the resolution of grievances to contracted medical groups.

- A "complaint" is any expression of dissatisfaction regarding the quality of service (excluding quality of care) which can be resolved in the initial contact. A "complaint" is self limiting (e.g. service complaints, appointment wait times) that can be resolved to the member's satisfaction, such as they do not ask for additional assistance

PROCEDURE:

A. The staff will ensure that any member who expresses a grievance or complaint is informed of the right for a State Fair Hearing and offered the following numbers:

1. The California Department of Managed Health Care 1-888-HM0-2219
2. For Hearing and Speech impaired call1-800-735-2929
3. State Fair Hearing 1-800-952-5253

B. Staff will ensure that grievance forms (in threshold languages) for each participating health plan will be provided to members promptly upon request.

- The grievance form must be submitted to the health plan within 1 business day.

C. The Staff will ensure that all complaints (self limiting complaints: e.g. service complaints, appointments wait times) are logged and submitted to the health Plan monthly (if were complaints during the time period).

1. These complaints may be resolved at the point of service
2. Log the complaint and include:
    a. Date of complaint
    b. Name of complainant and ID#
    c. Nature of the complaint
    d. Resolution/action taken (include information that health plan was notified as appropriate)
    e. Date of resolution/action
    f. Date log submitted to health plan

ATTACHMENTS: Grievance forms and log

Member Grievance Procedure

Definitions: Grievances are any written or oral expressions of dissatisfaction made by a member/patient regarding quality of service, access to care, interpersonal communication, or any other aspect of the physician/provider.

Purpose: To assure the quality and continuity of care given to Medi-Cal Managed Care patients/members. To monitor and resolve all quality of care issues and administrative issues through an internal grievance process.

Procedure to file a Grievance:

1. Patients/members may file a grievance with the Physician or Office Manager of the doctor's office.
2. They may file a grievance by telephone, correspondence, or a grievance report form.
3. If the grievance is filed by telephone: The office personnel must document the grievance on a grievance report form and submit a copy to the physician.
4. If the grievance is filed by correspondence: The office personnel must document the grievance on a grievance report form, attach the correspondence, and submit a copy to the physician.
5. If the grievance is filed by a grievance report: The office personnel must submit a copy to the physician.
6. The grievance form must be completed in its entirety with as much detail as possible.
7. If the grievance is solvable by the physician and office personnel, then documentation of the grievance must be kept on file and recorded on the grievance log.
8. If the grievance is not solvable by the physician and/or office personnel, then a copy of the grievance form and any supporting documents must be sent to the members/patients corresponding Health Plan within one (1) working day.
9. **All** grievances must be documented on a grievance form.
10. **All** grievances must be recorded and tracked on the grievance log.
11. **All** grievances must be resolved within twenty (20) days of the initial grievance. If the grievance is not resolved at the provider level within twenty (20) working days, the member must be offered the opportunity to file a written grievance with their corresponding Health Plan. This must be documented on the grievance form if the member/patient is offered to file a written grievance to their Health Plan, regardless of whether they agree or refuse the offer.

NOTE: All grievance forms, grievance logs, and supporting documents must be kept in a separate folder, not in the patient's medical records.

Blue Cross	Blue Shield Promise	CHP	Kaiser	L.A. Care
888-285-7801	800-605-2556	800-475-5550	800-464-4000	888-452-2273

DMHC	DMHC – TDD Line	Ombudsman
888-HMO-2219	877-688-9891	888-452-8609

http://www.hmohelp.ca.gov

blue california | promise HEALTH PLAN

GRIEVANCE FORM

MEMBER INFORMATION

Member Name (Last) (First)	Birth Date: Mo. Day Yr.	Effective Date of Enrollment: Mo. Day Yr.
Address (Street) (City) (State)		(ZIP Code)
Telephone (Home)	(Work)	Number of Plan Members in Family, Including Member Grievance:
Name of person completing form, if different from member name		(Daytime Telephone)

Where did the problem occur? (Name of Pharmacy, Hospital or Clinic)	Date of Incident: Mo. Day Yr.
Who was involved beside yourself? (Give names of involved staff, if possible.)	
Please describe what happened as specifically as possible: (Include the sequence of events and how the problem affected you.)	

See Attachment

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against Blue Shield Promise Health Plan, you should first telephone Blue Shield Promise Health Plan at **1-800-605-2556** (TDD/TTY for the hearing impaired at **1-877-735-2929**) and use Blue Shield Promise Health Plan's grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Blue Shield Promise Health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department of Managed Health Care also has a toll-free telephone number (**1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet web site, **http://www.hmohelp.ca.gov,** has complaint forms, IMR application forms, and instructions online.
You may also call the OMBUDSMAN (1-888-452-8609) to help you solve problems from a neutral standpoint to help you receive all medically necessary covered services.

ACTION REQUESTED

What would you like to see done about this problem?

See Attachment

Grievance Received By:	In Person ☐	
	By Telephone ☐	_____ Date
Date Received: Time Received	By Mail ☐	Member's Signature (optional) I UNDERSTAND THAT THE PLAN WILL CONTACT ME WITHIN THIRTY (30) DAYS TO GIVE ME A REPORT ON ITS INVESTIGATION AND/OR ACTION REGARDING MY COMPLAINT.
	Online ☐	

DESCRIBE WHAT HAPPENED:

ACTION REQUESTED:

(OFFICIAL USE ONLY)
OUTCOME/RESOLUTION:
(*Complete only if an Expedited Appeal*)
Member was acknowledged verbally and notified of the 72 hours appeal process: Yes ☐ No ☐
Grievance Received by: **Date Received:**

FORMULARIO PARA QUEJAS

INFORMACIÓN DEL MIEMBRO

Apellido	Nombre	Fecha de nacimiento: Mes	Día	Año	Día efectivo de inscripción: Mes	Día	Año

Domicilio	Ciudad	Estado	Zona postal

Teléfono de la casa	Teléfono del trabajo	Número de miembros inscritos incluyendo al demandante:

Nombre de la persona completando el formulario (representante), si es diferente del miembro	Télefono del representante

¿Dónde ocurrió el problema? (Nombre de la farmacia, hospital o clínica)	Fecha del incidente: Mes	Día	Año

Además de usted, mencione al personal que está implicado en su queja.

Favor de describir lo ocurrido tan especificamente sea posible (Incluya la secuencia de eventos y de que manera le afectó este problema. Use otra página si es necesario para describirlo con más detalle.)

Vea el documento adjunto

El Departamento de Atención Médica Administrada de California (DMHC, por sus siglas en inglés) se encarga de regular los planes de salud. Si usted tiene alguna queja sobre Blue Shield Promise Health Plan, debe llamar primero a Blue Shield Promise Health Plan, al **1-800-605-2556,** (para las personas con problemas auditivos, el teléfono TDD/TTY es **1-877-688-9891**) y seguir el trámite de quejas del plan, antes de comunicarse con el DMHC. El trámite de quejas no anula ningún derecho o recurso legal que usted pueda tener a su disposición. Si necesita ayuda con una queja relacionada con una emergencia, o con una queja que Blue Shield Promise Health Plan no haya resuelto satisfactoriamente, o si su queja lleva más de treinta (30) días sin ser resuelta, puede llamar a DMHC para pedir asistencia. Es posible que también pueda solicitar una Revisión Médica Independiente (IMR, por sus siglas en inglés). Si reúne los requisitos necesarios para la IMR, este proceso hará una revisión imparcial de las decisiones médicas tomadas por su plan de salud. El objetivo de la IMR es determinar la necesidad médica de un servicio o tratamiento propuesto y tomar decisiones sobre la cobertura de tratamientos de tipo experimental o de investigación y sobre disputas por el pago de servicios médicos urgentes o de emergencia. El DMHC cuenta también con un número de teléfono sin cargo **(1-888-HMO-2219)** y una línea TDD **(1-877-688-9891)** para las personas con problemas auditivos o del habla. La página web del DMHC, **http://www.hmohelp.ca.gov**, incluye formularios de queja, de solicitud de IMR e instrucciones en Internet.

ACCIÓN REQUERIDA

¿Qué medida(s) quisiera que se aplicaran a este problema?

Vea el documento adjunto

Queja recibida por:		En persona Por teléfono	
Fecha que se recibió:	Hora que se recibió:	Por correo En línea	Firma (Opcional) Fecha TENGO ENTENDIDO QUE EL PLAN SE COMUNICARÁ CONMIGO DENTRO DE 30 DÍAS PARA DARME UN INFORME SOBRE SU INVESTIGACIÓN Y/O SU ACCIÓN CON RESPECTO A ESTE PROBLEMA.

DESCRIBA LO QUE OCURRIO:

ACCIÓN REQUERIDA:

(OFFICIAL USE ONLY)

OUTCOME/RESOLUTION:

(*Complete only if an Expedited Appeal*)

Member was acknowledged verbally and notified of the 72 hours appeal process: Yes ☐ No ☐

Grievance Received by: **Date Received:**

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PROTOCOL FOR HOW TO ACCESS INTERPRETING SERVICES

(Face-to-Face, Over-the-Phone & American Sign Languages)

Why does Blue Shield of California Promise Health Plan provide Free Interpreting Services?

"Federal Law requires that health care providers who see all government programs mem-bers provide free language assistance to limited English proficient (LEP) and hard-of-hearing or deaf persons. In order for you to meet this legal requirement, Blue Shield of California Promise Health Plan is providing Over-the-Phone, Face-to-Face and American Sign Language (ASL) interpreting services at no cost to Blue Shield of California Promise Health Plan providers and members."

When is Over-the-Phone Interpreting Services recommended?

- When you identify a patient as being limited English proficient (LEP) and the patient is already present at the office, telephone interpretation should be used immediately to avoid any delay in service.
- Telephone interpretation is available 24 HOURS A DAY, 7 DAYS A WEEK.
- When a LEP patient requests it.

DURING BUSINESS HOURS:

1. Call Blue Shield of California Promise Health Plan Customer Service Department

Medi-Cal (All counties).....**1-800-605-2556**

Medicare & Commercial (All counties)..**1-800-544-0088**

Dual Demo (All counties).....**1-855-905-3825**

OR

2. Call Pacific Interpreters

Alameda .....(ACCESS CODE: 845311) **1-877-904-8195**

Los Angeles .....(ACCESS CODE: 840609) **1-877-904-8195**

San Diego .....(ACCESS CODE: 838600) **1-877-904-8195**

San Francisco ..(ACCESS CODE: 845310)....**1-877-904-8195**

San Joaquin....(ACCESS CODE: 842613).....**1-877-904-8195**

Santa Clara.....(ACCESS CODE: 841676)....**1-877-904-8195**

Stanislaus .....(ACCESS CODE: 842615).....**1-877-904-8195**

Texas.....(ACCESS CODE: 846273) **1-877-904-8195**

AFTER BUSINESS HOURS:

1. Call Pacific Interpreters

All counties (ACCESS CODE: 828201)
1-877-904-8195

- A Pacific Interpreters Customer Service Agent will ask for the following information:
  - ACCESS CODE
  - Member's First & Last Name & Blue Shield of California Promise Health Plan ID#
  - Language Needed

2. - Is this a Medi-Cal/Medicare/Dual Demo or Commercial Member?
If your office has After Hours Answering Services: Please ensure that their staff members can speak languages other than English; Please ensure that they know how to connect to an interpreter over the telephone.

3. If your office has On-Call Physicians/Nurses: Please ensure that they know how to connect to an interpreter over the telephone.

4. If your office has an answering machine:
Please let the patients know that they need to call Pacific Interpreters.

When are Face-to-Face and American Sign Language interpreting services recommended?

- To explain complex medical consultation or education (i.e. medical diagnosis, treatment options, insulin instructions, etc.) to a LEP or a hard-of-hearing or deaf member.

- When a LEP patient requests it.

  All requests must be made with advance notice (amount of days may vary based on the company), please contact Blue Shield of California Promise Health Plan Customer Services Department for further assistance:

Medi-Cal	**1-800-605-2556**
Medicare & Commercial	**1-800-544-0088**
Dual Demo	**1-855-905-3825**

When is LifeSigns (American Sign Language) recommended?

- In case of emergency or after business hours for American Sign Language (ASL) interpreter, please call: LifeSigns at 1-800-633-8883

Please contact Blue Shield of California Promise Health Plan Customer Services Department at least 48 Hours in advance if the appointment has been CANCELLED or RESCHEDULED.

When is California Relay Service (TTY/Telecommunication Device for Deaf - TDD) recommended?

- When your office staff need to communicate with the hard-of-hearing or deaf patients, please call California Relay Service:

  English **1-888-877-5379**
  Spanish **1-888-877-5381**

- When your hard-of-hearing or deaf patients need assistance to call your office or Blue Shield of California Promise Health Plan, please dial:

  1-800-735-2929 (Los Angeles) or **711**
  1-866-461-4288 (San Diego)

PLEASE KEEP IN MIND:

1. Always document the member's preferred language in the member's medical record.
2. Always document the request or refusal of interpreting services in the member's medical record.
3. Always post an "Interpreting Services Signs" at key medical and non-medical points of contact.
4. Please discourage patients of using friends and family members as interpreters unless the member requests it after being informed about the availability of the free interpreter services.

إذا كنت بحاجة إلى هذه المعلومات بلغتك، يرجى الإتصال بالهاتف المجاني أو في شكل بديل (برايل أي بأحرف كبيرة أو الصوت) 1-800-605-2556.

ARABIC

Եթե Ձեզ անհրաժեշտ է այս տեղեկատվությունը Ձեր լեզվով կամ այլընտրանքային ձեւաչափով (այսինքն Braille, մեծ Տպել կամ ԱՄՆ), խնդրում ենք զանգահարել մեր տուրք անվճար համարը 1-800-605-2556.

ARMENIAN

如果您需要中文版的資訊或其他版本格式（例如盲文、大號字體印刷版或錄音等）， 請撥打我們的免費電話號碼 1-800-605-2556。

CHINESE

If you need this information in your language or in an alternative format (i.e. Braille, Large Print or Audio), please call our toll free number 1-800-605-2556.

ENGLISH

اگر لازم است این اطلاعات را به زبان خودتان و یا در قالب جایگزین (به عنوان مثال خط بریل ، بزرگ چاپ و یا صوتی) ، لطفا با شماره تلفن رایگان تعداد تلفات ما 1-800-605-2556.

FARSI

បើសិនជាអ្នកត្រូវការពត៌មាននេះជាភាសាខ្មែរ ឬទ្រង់ទ្រាយទីទៃៗទៀត
(ដូចជាអក្សរប្រល្លិសំរាប់មនុស្សពិការ ភ្នែក, សម្ភរៈមានសំណេរអក្សរធំៗ, ឬខ្សែអាត់សំឡេងជាដើម),
សូមទូរស័ព្ទទៅលេខ 1-800-605-2556 ។ ពុំមានអស់ថ្លៃអ្វី សំរាប់ការទូរស័ព្ទនេះឡើយ ។

KHMER

당신은 (예 : 점자), 우리의 수신자 부담 전화 번호 1-800-605-2556 로 문의하십시오 대형 인쇄 또는 오디오를 귀하의 언어로이 정보 또는 다른 형식이 필요한 경우.

KOREAN

Если Вам нужна эта информация на русском языке или в альтернативном формате (например, шрифт Брайля, крупным шрифтом или Audio), просьба звонить по бесплатному телефонному номеру 1-800-605-2556.

RUSSIAN

Si necesita esta información en español, o en formato alterno (por ejemplo, braille, letra grande o audio), por favor llame al 1-800-605-2556. Esta llamada es gratuita.

SPANISH

Kung kailangan mo ang impormasyon na ito sa iyong wika o sa isang alternatibong format (i.e. Braille, Large Print o Audio), mangyaring tumawag sa aming walang-bayad na numero 1-800-605-2556.

TAGALOG

Nếu bạn cần thông tin này trong ngôn ngữ của bạn hoặc trong một định dạng khác (ví dụ như chữ nổi, lớn In hoặc Audio), xin vui lòng gọi số điện thoại miễn phí của chúng tôi số 1-800-605-2556.

VIETNAMESE

PCP	Page 1 of 1
Section: Office Management	
POLICY AND PROCEDURE: Interpreter Services	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:_____

POLICY:
The site has twenty-four hour access to Interpreter services for non/limited English proficient (LEP) members.

PROCEDURE:

A. Staff will ensure that Interpreter services are made available in identified threshold languages specified for location of site.

B. The PCP will ensure that all personnel providing language interpreter services on site are trained in medical interpretation.

C. The provider/designee will assess interpreter skills and capabilities as follows:

1. Assessment of interpreter skills may include written or oral assessment of bilingual skills
2. Documentation of the number of years of employment as an interpreter or translator
3. Documentation of successful completion of a specific type of interpreter training programs, i.e. medical, legal, court or semi-technical.
4. Other reasonable alternative documentation of interpreter capability

D. Staff will document in the medical record any request for, or refusal of language/interpreter services; staff will document primary language for the member.

E. The PCP will ensure that 24-hour interpreter services are available for all members either through telephone language services or interpreters on site.

Access to Materials in Other Languages & Alternative Format

Health Education and Member informing materials are available to members in English, Spanish, Arabic, Armenian, Farsi, Korean, Chinese, Khmer (Cambodian), Russian, Tagalog, and Vietnamese. Other languages are available by request. To request materials in another language or in an alternative format, Braille, Electronic Text File, Audio, or Large Print after format. Please contact Blue Shield Promise Health Plan C&L Department at **1-800-605-2556 or online at** https://www.blueshieldca.com/promise/providers/index.asp?secProviders=cultural-and-linguistics

Primary Language Spoken__________________
Needs Interpreter YES _____ NO_____

Primary Language Spoken__________________
Needs Interpreter YES _____ NO_____

Primary Language Spoken__________________
Needs Interpreter YES _____ NO_____

Primary Language Spoken__________________
Needs Interpreter YES _____ NO_____

Primary Language Spoken__________________
Needs Interpreter YES _____ NO_____

Primary Language Spoken__________________
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Needs Interpreter YES _____ NO_____

Primary Language Spoken__________________
Needs Interpreter YES _____ NO_____

Primary Language Spoken__________________
Needs Interpreter YES _____ NO_____

Primary Language Spoken__________________
Needs Interpreter YES _____ NO_____

Request/Refusal Form for Interpretive Services

Patient name: _____

Primary language: _____

- ☐ **Yes, I am requesting interpretive services.**
  Language(s): _____
- ☐ **No, I prefer to use my family or friend as an interpreter.**
- ☐ **No, I do not require interpretive services.**
- ☐ **Not Applicable.**

Please explain: _____

_____

_____ _____

Patient Signature **Date**

Please place this form in the patient's medical record.

Formulario Para Solicitar/Rechazar Servicios de Intérprete

Nombre del paciente: _____

Idioma preferido: _____

☐ **Si, necesito servicios de intérprete.**
Idioma(s): _____

☐ **No, Prefiero utilizar un familiar o amistad como intérprete.**

☐ **No, requiero servicios de intérprete.**

☐ **No, me corresponde.**

Por favor explique: _____

_____

_____ _____

Firma del paciente **Fecha**

Please place this form in the patient's medical record.
Request/Refusal - Spanish

PCP	
Section : Office Management	
POLICY AND PROCEDURE: Medical Records	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:_____

POLICY:

The Medical record shall be maintained to serve the patient/member and health care provider in compliance with legal, accrediting and regulatory agency requirements. All member information is regarded as confidential and obtainable only to authorized persons. Medical Records shall be maintained in accordance with medical legal documentation standards including but not limited to health plan operation manual medical record documentation and medical record keeping standards.

PROCEDURE:

A. The provider/designee will ensure that there is a system for the following:
    1. Medical records are available at each encounter and includes outpatient, inpatient, referral services, and significant consultations. There must be a separate medical record for each patient

    2. Medical records are accessible within the facility, or an approved health record storage facility on the facility premises.

B. Staff will ensure that exam rooms and dressing areas safeguard patient's right to privacy.

C. Staff will maintain confidentiality of individual patient information. Individual patient conditions or information not discussed in front of other patients or visitors, displayed or left unattended in reception and/or patient flow areas.

D. Where applicable, electronic record-keeping system procedures are established to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain upkeep of computer systems. Security protection includes an off-site backup storage system, an image mechanism with the ability to copy documents, a mechanism to ensure that recorded input is unalterable, and file recovery procedures.

Confidentiality protection may also include use of encryption, detailed user access controls, transaction logs, and blinded files.

E. The PCP will ensure that medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released. The release will indicate to whom released and for what purpose. This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities and State or local official agencies.

F. The PCP will ensure that medical records are maintained for a minimum of 7 years following patient discharge, except for minors. Records of minors must be maintained for at least one year after a minor has reached age 18, but in no event for less than 7 years. Each Plan must maintain all records and documentation, including medical records, necessary to verify information and reports required by statute, regulation or contractual obligation for 5 years from the end of the fiscal year in which the plan contract expires or is terminated.

Signature Page

(Please post on the left-hand side of each Medical Record)

Please write signature as entries are typically signed	Print Name in Full (First Name, Last Name, Title)

Advance Directive Reminder

Advance directives should be discussed with each Blue Shield of CA Promise Health Plan member 18 years of age and older. State and Federal requirements must be followed accordingly. An advance directive outlines a patient's preferred types of health care services and treatments, and designates who is to speak on the patients behalf if he or she becomes incapable of making personal health care decisions. According to the federal patient self Determination Act (PSDA), patients with decision-making capabilities have the right to accept or refuse medical treatment or life sustaining procedures. Blue Shield of CA Promise Policies states that any adult member age 18 or older has the right to prepare an Advance Directive. Discussing and preparing advance directives with patient's can:

- Ensure the care and services desired by the patients are provided according to his or her wishes, including the refusal of treatment.
- Designate the person who is delegated to make decisions on the patient's behalf if he or she becomes incapable of making such decisions.
- Ensure family and friends abide by the wishes of the patient regarding the type of care and treatment determined in advance.

DISCUSSING AND DOCUMENTING ADVANCE DIRECTIVES

Providers should consider discussing advance directives during routine office visits with Blue Shield of CA Promise members, instead of waiting until a member is acutely ill. Blue Shield of CA Promise makes available a patient education reference for provider use when discussing this topic. The Advance Medical Directive reference is available, in English and Spanish, and is attached to this reminder.

If an advance directive is prepared by a Blue Shield of CA Promise member, encourage the member to share a copy with his or her family to notify them about who is designated to make decisions on the member's behalf in the event he or she can no longer make personnel health care decisions. This may initiate early health care planning discussions to enable a smoother transition before there is a medical crisis. It should be documented in the patient's medical record whether an advance directive had been discussed or executed and if possible a copy should be in the medical record.

ADDITIONAL INFORMATION

Physician orders for life-sustaining treatment (POLST) programs provide an organized process for completing advance directives. More information on advance directives and POLST are available on the following web sites:

- https://familydoctor.org/advance-directives-and-do-not-resuscitate-orders/
- https://polst.org/
- https://www.chcf.org/topic/serious-illness-end-of-life-care/
- https://www.cancer.org/treatment/finding-and-paying-for-treatment/understanding-financial-and-legal-matters/advance-directives/types-of-advance-health-care-directives.html

If you have any further questions regarding the information in this update please contact the Facility Site Review Unit of Blue Shield of CA Promise Health Plan Quality Improvement Department at:

- 323-827-6139
- 323-888-0968 Fax

What You Should Know About Advance Directives

What is an advance directive?

An advance directive is a legal document that Says how you want to be cared for if you are unable to make decisions. You can include what medical treatments you would want and who you would trust to make decisions for you .

An advance directive can also include other legal documents. A living will is a list of treatment preferences. It can be used to indicate whether you would want cardiopulmonary resuscitation (CPR) , tube feedings, a breathing machine, or certain medicines, like antibiotics.

The durable power of attorney for health care document identifies the person you would want to make medical decisions for you. This person is also called a proxy. Your proxy should be familiar with your values and wishes.

What should I include?

Be specific. Avoid terms like "terminally ill" or "no heroics". These words can mean different things to different people.

Situations to consider might include if you are permanently unconscious or become dependent on the care of others to survive.

Try to emphasize what is most important to you in a variety of situations.

A witness should sign the form . A notary may also need to sign the form. Keep a copy in a safe place, and tell family members and your proxy where it is.

Give your doctor a copy and ask him or her to put it in your medical record at the office and at your hospital.

How Do I get started?

You can get advance directive documents for Your state from your doctor's office or from https:// www.nhpco.org/ Review the forms, and ask your doctor if you have any questions. Pick a person to be your proxy, and talk it over with that person.

What happens after I complete it?

Your advance directive can be changed or canceled any time. It is important to continue discussing your wishes with Your wishes with your doctor and proxy.

Where can I get more information?

Your Doctor

AAFP'S Patient Education Recourse

Web site: http://familydoctor.org/003.xml

Advance Medical Directive

An advance medical directive is a form that lets you plan ahead for the care you'd want if you could no longer express your wishes. This statement outlines the medical treatment you'd want or names the person you'd wish to make health care decisions for you.

Writing Down Your Wishes

- Decide what is important to you and the treatment you'd want.
- An Advance Directive is important whether you're young or old. Injury or illness can strike at any age.
- Some states allow only on kind of advance directive. Some let you do both at durable Power of Attorney for Health Care and a Living Will. Some states put both kinds on the same form,

A Durable Power Of Attorney for Health Care

- This form lets you name someone else to be your agent.
- This person can decide on treatment for you only when you can't speak for yourself.
- You do not need to be at the end of your life. He or she could speak for you if you were in a coma but more likely to recover.

A living Will

- This form lets you list the care you want at the end of your life.
- A living will applies only if you won't live without medical treatment. It would apply if you had advanced cancer or a massive stroke. .
- It takes effect only when you can no longer express your wishes yourself.

Instrucciones Medicas Anticipadas

Un formulario de Instrucciones Medicas Anticipadas le permite a usted planear con anticipacion el nivel de atencion medica que quisiera recibir en caso de no poder expresar lo que decea. Esta declaracion describe el tratamiento medico que desearia recibir o nombra a las personas que quisiera que tomaran por usted cualquier decision sobre la atencion medica.

Ponga por escrito lo que desea

- Decida lo que es importante para usted y el tratamiento que desearia recibir.
- Es importante dar instrucciones medicas anticipadas ya sea usted joven o de edad avanzada. Las lesions o enfermedades pueden presentarce a cualquier edad.
- Algunos estados solamente permiten una clase de instrucciones medicas anticipadas.
  Otros permiten dos: un poder legal duradero para el cuidado medico y un testamento en vida. Por ultimo, otros estados combinan ambos documentos en un mismo formulario

Un poder legal para el cuidado medico

- Este formulario le permite a usted nombrar a alguien para que sea su agente (o apoderado).
- Esta persona puede decidir el tratamiento que usted reciba solamente cuando usted no pueda expresarse por si mismo.
- No es necesario que usted se este muriendo para que su agente pueda actuar. Por ejemplo, su agente prodria decider por usted si usted econtrara en un coma del cual problablememte se prodria recuperar.

Un testamento en Vida

- Este formulario le permite a usted hacer una lista de la atencion que quisiera recibir al final de su vida.
- Un testamento en vida solamente se aplica si usted no fuera a vivir sin tratamiento medico, como en el caso de un cancer avanzado o de un derrame cerebral masivo.
- Entra en efecto solamente cuando usted ya no puede expresar sus deseos.

Advance Directive Education: Date___________
Refused_______ Yes ______ Initials: ___________

Advance Directive Education: Date___________
Refused_______ Yes ______ Initials: ___________

Advance Directive Education: Date___________
Refused_______ Yes ______ Initials: ___________

Advance Directive Education: Date___________
Refused_______ Yes ______ Initials: ___________

Advance Directive Education: Date___________
Refused_______ Yes ______ Initials: ___________

Advance Directive Education: Date___________
Refused_______ Yes ______ Initials: ___________

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Refused_______ Yes ______ Initials: ___________

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Advance Directive Education: Date___________
Refused_______ Yes ______ Initials: ___________

Advance Directive Education: Date___________
Refused_______ Yes ______ Initials: ___________

Directiva anticipada de atención de la salud

Nombre: _____

Fecha: _____

Usted tiene derecho a dar instrucciones sobre la atención de su salud. También tiene derecho a designar a otra persona para que tome decisiones sobre la atención de su salud en su nombre. Este formulario también le permite escribir sus deseos sobre la donación de órganos y la designación de su médico de atención primaria. Si utiliza este formulario, puede completarlo o cambiar cualquier parte del mismo. También puede utilizar un formulario diferente, si lo desea.

Tiene derecho a cambiar o revocar esta Directiva anticipada de atención de la salud en cualquier momento.

Parte 1 – Poder legal para la atención de la salud

(1.1) DESIGNACIÓN DEL AGENTE: Designo a la siguiente persona como mi agente para que tome decisiones de atención de la salud en mi nombre:

Nombre de la persona que elige como agente: _____

Relación: _____

Dirección: _____

_____

Teléfonos: Casa: _____ Trabajo: _____ Celular: _____

AGENTE SUSTITUTIVO (Optativo): Si revoco la autoridad de mi agente o mi agente no está dispuesto, no es capaz o no se halla razonablemente disponible para tomar una decisión de atención de la salud en mi nombre, designo como mi primer agente sustitutivo a:

Nombre de la persona que elige como agente sustitutivo: _____

Relación: _____

Dirección: _____

_____

Teléfonos: Casa: _____ Trabajo: _____ Celular: _____

SEGUNDO AGENTE SUSTITUTIVO (Optativo): Si revoco la autoridad de mi primer agente y de mi primer agente sustitutivo, o si ninguno de los dos está dispuesto, es capaz o se halla razonablemente disponible para tomar una decisión de atención de la salud en mi nombre, designo como mi segundo agente sustitutivo a:

Nombre de la persona que elige como segundo agente sustitutivo: _____

Dirección: _____

_____

Teléfonos: Casa: _____ Trabajo: _____ Celular: _____

(1.2) AUTORIDAD DEL AGENTE: Mi agente está autorizado a 1) tomar todas las decisiones de atención de la salud en mi nombre, incluyendo decisiones para proporcionar, retener o retirar la nutrición y la hidratación artificiales y todas las otras formas de atención de la salud para mantenerme vivo, 2) elegir una institución de atención de la salud o un médico específicos y 3) recibir o consentir que se divulgue información y datos médicos, excepto como lo indico a continuación: _____

_____

(Si es necesario, añada hojas.)

(1.3) CUÁNDO ENTRA EN VIGOR LA AUTORIDAD DE MI AGENTE: La autoridad del agente entra en vigor cuando mi médico primario determina que soy incapaz de tomar mis propias decisiones de atención de la salud, a menos que ponga mis iniciales en la próxima línea.

Si pongo mis iniciales en esta línea, deseo que mi agente tome decisiones inmediatamente sobre la atención de mi salud, incluso si todavía puedo tomarlas por mí mismo. _____

(1.4) OBLIGACIÓN DEL AGENTE: Mi agente tomará decisiones sobre la atención de mi salud en mi nombre de conformidad con este poder legal para la atención de la salud, con todas las instrucciones que doy en la Parte 2 de este formulario y con mis otros deseos en la medida en que los conozca mi agente. En los casos en que mis deseos se desconozcan, mi agente deberá tomar decisiones de atención de mi salud en mi nombre de conformidad con lo que mi agente determine que sea mi mejor interés. Al determinar mi mejor interés, mi agente deberá tener en cuenta mis valores personales en la medida en que mi agente los conozca.

(1.5) AUTORIDAD DEL AGENTE POSTERIOR A LA MUERTE: Mi agente está autorizado a realizar donaciones anatómicas, autorizar una autopsia o indicar lo que hará con mis restos, excepto como lo indico aquí o en la Parte 3 de este formulario: _____

_____

(Si es necesario, añada hojas.)

(1.6) NOMBRAMIENTO DE UN TUTOR ADMINISTRATIVO: Si la corte necesita nombrar un tutor administrativo de mi persona, nombro al agente designado en este formulario. Si el agente no está dispuesto, no es capaz, o no se halla razonablemente disponible para actuar como tutor administrativo, nombro a los agentes sustitutivos que nombré. _____ (ponga aquí sus iniciales)

Parte 2 – Instrucciones para la atención de la salud

Si llena esta parte del formulario, puede tachar todo lo que no desee.

(2.1) **DECISIONES PARA EL FINAL DE LA VIDA:** Indico a mis profesionales de la salud y a otras personas que participen en mi atención que proporcionen, retengan o retiren el tratamiento de conformidad con la opción que marqué a continuación:

☐ a) Opción de no prolongar
No deseo que se prolongue mi vida si los posibles riesgos y cargas del tratamiento serán mayores que los beneficios esperados o si pierdo el conocimiento y si con un grado realista de certeza médica no recuperaré el conocimiento, o si tengo un trastorno incurable e irreversible que resultará en mi muerte en un plazo relativamente breve.

O bien,

☐ b) Opción de prolongar
Deseo que mi vida se prolongue lo más posible dentro de los límites de las normas médicas de aceptación general.

(2.2) OTROS DESEOS: Si tiene instrucciones diferentes o más específicas aparte de las que marcó anteriormente, tales como: lo que usted considera como una calidad de vida razonable, los tratamientos que considera como una carga o inaceptables, escríbalos aquí.

_____

_____

_____

_____

_____

(Si es necesario, añada hojas.)

Parte 3 - Donación de órganos al morir (optativo)

(3.1) Al morir (marque la casilla que corresponda):

☐ Dono todos los órganos, tejidos o partes que sean necesarias

☐ Dono únicamente los siguientes órganos, tejidos o partes

☐ No deseo donar órganos, tejidos ni partes.

Mis donaciones para los siguientes fines (tache todos los siguientes que no desee):

Transplante Terapia Investigación Educación

Parte 4 - Médico de atención primaria (optativo)

(4.1) Designo al siguiente médico como mi médico de atención primaria:

Nombre del médico: _____

Dirección: _____

_____

Teléfono: _____

Parte 5 – Firma

(5.1) EFECTO DE UNA COPIA: Una copia de este formulario tiene el mismo efecto que el original.

(5.2) FIRMA: Firme su nombre:_____Fecha: _____

(5.3) ENUNCIADO DE TESTIGO: Declaro bajo pena de perjurio de conformidad con las leyes de California (1) que conozco personalmente a la persona que firmó o aceptó esta directiva anticipada de atención de la salud o que la identidad de dicha persona me fue probada mediante prueba convincente, (2) que la persona firmó o aceptó esta directiva anticipada en mi presencia, (3) que la persona parece estar en su sano juicio y no estar bajo coacción, fraude o coerción indebida, (4) que no soy la persona nombrada como agente en esta directiva anticipada y (5) que no soy el profesional de la salud de la persona, ni un empleado del profesional de la salud de la persona, ni el operador de una institución comunitaria de atención, ni el empleado de un operador de una institución comunitaria de atención, ni el operador de una institución residencial de cuidado de ancianos, ni un empleado del operador de una institución residencial de cuidado de ancianos.

PRIMER TESTIGO

Nombre en letra de molde: _____

Dirección: _____

Firma del testigo: _____Fecha: _____

SEGUNDO TESTIGO

Nombre en letra de molde: _____

Dirección: _____

Firma del testigo: _____Fecha: _____

(5.4) DECLARACIÓN ADICIONAL DE LOS TESTIGOS: A menos uno de los testigos que anteceden también debe firmar la siguiente declaración:

Declaro además bajo pena de perjurio de conformidad con las leyes de California que no tengo ningún parentesco directo, por matrimonio o por adopción con la persona que firma esta directiva anticipada y que, de mi mejor saber, no tengo derecho a ninguna parte de la herencia de la persona cuando muera de conformidad con un testamento ahora existente ni por mandato de ley.

Firma del testigo: _____

Firma del testigo: _____

Parte 6 - Requisito especial del testigo si usted se halla en una institución de enfermería especializada

(6.1) El defensor u "ombudsman" del paciente debe firmar la siguiente declaración:

DECLARACIÓN DEL DEFENSOR (OMBUDSMAN) DEL PACIENTE

Declaro bajo pena de perjurio de conformidad con las leyes de California que soy defensor u "ombudsman" del paciente designado por el Departamento de la Vejez de California y que sirvo como testigo según lo requiere la sección 4675 del Código Testamentario:

Nombre en letra de molde: _____ Firma: _____

Dirección: _____ Fecha: _____

Certificación del notario público (no se requiere si la firman dos testigos)

Estado de California, Condado de _____. Hoy, _____ de _____de _____, compareció personalmente ante mí, notario público abajo firmante en y autorizado por dicho Estado, _____, a quien conozco personalmente o que se me probó con pruebas satisfactorias que se trata de la persona cuyo nombre se halla firmado en el presente instrumento, que me indicó que lo aceptó.

En fe de lo cual, firmo y pongo mi sello oficial [Seal]

Firma _____

Instrucciones para el formulario de la directiva anticipada para la atención de la salud

Tiene derecho a dar instrucciones sobre la atención de su salud.

También tiene derecho a designar a otra persona para que tome decisiones de atención de su salud en su nombre

El formulario Directiva anticipada de atención de la salud le permite hacer una o ambas cosas. También le permite escribir sus deseos sobre la donación de órganos y la elección de su médico de atención primaria. Si utiliza el formulario puede completar o cambiar cualquier parte del mismo o todo el formulario. También puede utilizar un formulario diferente.

INSTRUCCIONES

Parte 1: Poder legal

La Parte 1 le permite:

- **Nombrar** a otra persona como su **agente** para que tome decisiones de atención de su salud en su nombre si usted no puede tomar sus propias decisiones. También puede hacer que su agente tome decisiones en su nombre inmediatamente, incluso si todavía puede tomar sus propias decisiones.
- **Nombrar también** a un **agente sustitutivo** para que actúe su nombre si el agente que eligió como su primera opción no está dispuesto, no es capaz o no se halla disponible razonablemente para tomar decisiones en su nombre.

Su **agente** no puede ser:

- Un operador ni un empleado de una institución comunitaria de atención ni de una institución residencial de atención en la que usted está recibiendo atención.
- El profesional de la salud que supervisa su atención (el médico maneja su atención).
- Un empleado de una institución de atención de la salud en la que usted esté recibiendo atención, a menos que su agente sea un pariente suyo o un compañero de trabajo.

Su **agente** puede tomar todas las decisiones de atención de la salud en su nombre, a menos que limite la autoridad de su agente. No está obligado a limitar la autoridad de su agente.

Si quiere limitar la autoridad de su agente, el formulario incluye un espacio para hacerlo.

Si usted opta por no limitar la autoridad de su agente, su agente tendrá derecho a hacer lo siguiente:

- Prestar consentimiento a o rechazar toda atención, tratamiento, servicio o intervención para mantener, diagnosticar o de alguna otra manera afectar un trastorno físico o mental.
- Elegir o despedir profesionales e instituciones de atención de la salud (esto es, elegir un médico en su nombre).
- Estar de acuerdo o en desacuerdo con los análisis de diagnóstico, las intervenciones quirúrgicas y los planes de medicamentos.
- Estar de acuerdo o en desacuerdo con proporcionar, retener o retirar la alimentación y los fluidos artificiales y todas otras formas de atención de la salud, incluyendo la resucitación cardiopulmonar (RCP).
- Realizar donaciones anatómicas después de su muerte (donar órganos y tejidos), autorizar una autopsia y tomar decisiones sobre lo que se hará con su cuerpo.

Parte 2: Instrucciones para la atención de la salud

Puede dar instrucciones específicas sobre cualquier aspecto de la atención de su salud, independientemente de si nombra o no a un agente.

El formulario contienen opciones diseñadas para ayudarle a escribir sus deseos sobre proporcionar, retener o retirar el tratamiento para mantenerlo vivo.

También puede añadir las elecciones que haya tomado o escribir deseos adicionales.

No necesita llenar la parte 2 de este formulario si desea permitir que su agente tome las decisiones sobre la atención de su salud que

considere que sean las mejores para usted sin añadir sus instrucciones específicas.

Parte 3: Donación de órganos

Puede escribir sus deseos sobre donar los órganos y tejidos de su cuerpo después de su muerte.

Parte 4: Médico de atención primaria

Puede elegir un médico para que tenga la responsabilidad primaria o principal de la atención de su salud.

Parte 5: Firma y testigos

Después de completar el formulario, **fírmelo y póngale la fecha** en la sección provista.

El formulario tiene que estar firmado **por dos testigos calificados** (vea la declaración de los testigos incluida en este formulario) **o** aceptado ante notario público. **Si dos testigos firman el formulario, no es obligación que lo firme un notario. Los testigos tienen que firmar el formulario en la misma fecha en que lo firme la persona que realice la Directiva anticipada.**

Si es un paciente en una institución de enfermería especializada vea la parte 6.

Parte 6: Requisito de testigo especial

Un defensor u "ombudsman" del paciente debe atestiguar el formulario ***si usted es paciente en una institución de enfermería especializada*** (una institución de atención de la salud que proporciona atención de enfermería especializada y atención de apoyo a pacientes). Vea la Parte 6 del formulario.

[Ok not to have boxes on top 2 items – for better readability]

Tiene derecho a cambiar o revocar su Directiva anticipada de atención de la salud en cualquier momento.

Si tiene preguntas sobre completar la Directiva anticipada en el hospital, pida hablar con un capellán o un asistente social.

Le solicitamos que
llene este formulario en inglés,
para que las personas encargadas de atenderlo
puedan entender sus instrucciones.

Authorization to Use and Disclose Protected Health Information

Authorization to release the protected health information of:		
Patient Name:	MRN	EMPL #
Current Address	City	State Zip
Social Security Number - -	Phone Number ( )	Date of Birth / /
This authorization is to release protected health information to:		
Name		Phone Number ( )
Address	City	State Zip
This authorization is to release protected health information from		
Facility Name/Provider		Phone Number ( )
Address	City	State Zip
The Purpose of this disclosure is:		
Dates of service:		

Release the following:

☐ Discharge Summary	☐ Pathology Report(s)	☐ Alcohol/Drug Treatment Record(s)*
☐ History & Physical	☐ Radiology Report(s)	☐ Itemized Billing Statement
☐ Consultation(s)	☐ Lab Report(s)	☐ Other records as specified:
☐ Operative Report(s)	☐ Cardiology Report(s)	_____
☐ Progress Notes	☐ Psychiatric Record(s)	_____
☐ Emergency Record(s)	Treatment Plan(s)	

This Authorization will remain in effect:

☐ From the date of this Authorization until: _____

☐ Until the following event occurs: _____

Unless otherwise noted above this authorization will remain in effect 180 days from the date signed.

I understand that:

- Once *"this facility"* discloses my health information by my request, it cannot guarantee that Recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law in governing the use and disclosure of my health information.
- I may make a request in writing at any time to *"this facility"* to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR §164.524
- This Authorization will remain in effect until the Authorization expires or I provide a written notice of revocation to the Health Information Services/Medical Record Department. If I revoke this Authorization, IHC may not be able to reverse the use or disclosure of my health information while the Authorization was in effect.

To be used if facility requests this authorization:

I understand that:

- I may refuse to sign or may revoke this Authorization at any time for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of *'this facility's"* treatment of me, enrollment in the health plan, or eligibility for benefits.
- I may make a request in writing at any time to *"this facility"* to inspect and/or obtain a copy of the protected health information maintained at this facility to be used or disclosed as provided in the Federal Privacy Rule 456 CFR §164.254

*Alcohol/drug treatment records are protected by Federal Rule 42 CFR, Part 2

If I have questions about disclosure of my health information, I can contact the Health Information Services / Medical Records Department.

Signature of Patient or Legal Representative	Date
If Signed by Legal Representative, Relationship to Patient	Signature of Witness (optional)

Autorización para utilizar y revelar información protegida relativa a la salud

Autorización para revelar la información relativa a la salud de:		
Nombre	MRN	EMPL #
Dirección Actual	Ciudad	Estado Código Postal
Número de Seguro Social - -	Numero de Teléfono ( )	Fecha de Nacimiento / /
Esta autorización es para revelar información a:		
Nombre		
Dirección	Cuidad	Estado Código Postal
El propósito de esta revelación es:		
Fechas del Servicio:		

Tenga el favor de enviar la información con un tilde para lo siguiente:

- ☐ Resumen de alta ☐Informe(s) de patología ☐Informe(s) para tratamiento de alcohol/drogas*
- ☐ Historial & Chequeo médico ☐ Informe(s) de radiología ☐Detalle de cobros
- ☐ Consulta(s) ☐ Informe(s) de laboratorio ☐Otros informes según se especifica
- ☐ Informe(s) quirúrgico ☐ Informe(s) de cardiología _____
- ☐ Comentarios de progreso ☐ Informe(s) psiquiátrico _____
- ☐ Informe(s) de emergencias ☐ Plan(es) para tratamiento

Plazo: esta autorización tendrá efecto:

- ☐ Desde la fecha de la autorización hasta:_____
- ☐ Hasta que ocurra lo siguiente:_____

De lo contrario esta autorización tendrá efecto por 180 días a partir de la fecha indicada.

Entiendo que:

- Una vez que *"esta institución"* divulgue la información acerca de mi salud según mi pedido, no garantiza que el Destinario no revelara nuevamente mi formación a un tercero. El tercero puede no tener que acatar esta Autorización o las leyes federales y estatales correspondientes que rigen el uso y divulgación de la información relativa a mi salud.
- Puedo realizar un pedido por escrito en cualquier momento a *"esta institución"* para examinar y/o obtener una copia de la información relativa a mi salud mantenida en esta institución según el Reglamento de Privacidad Federal (Federal Privacy Rule 45 CFR §164.524
- esta Autorización estará en vigencia hasta que la Autorización caduque o yo notifique por escrito su revocación al Servicios de información de la salud/Departamento de información medica (Health Information Services / Medical Record Department).

Para ser utilizado si la institución solicita esta autorización:

Entiendo que:

- Puedo negarme a firmar o puedo revocar esta Autorización en cualquier momento y por cualquier causa y dicha negación o revocación no afectara el inicio, continuación o calidad del tratamiento que *"esta institución"* me facilita, la inspiración en el plan de salud, o los requisitos para los beneficios.
- Realizo un pedido por escrito en cualquier momento a "esta institución" para examinar y/o obtener una copia de información protegida relativa a mi salud mantenida en esta institución para ser usada o divulgada según el Reglamento de Privacidad Federal (Federal Privacy Rule 45 CFR § 164.524).

Los informes de tratamientos de Alcohol/Drogas están protegidos por el reglamento Federal CFR, parte 2.

Si tengo dudas acerca de la divulgación de la información relativa a mi salud, puedo contactar a servicios de información de la salud/ Departamento de información médica (Health Information Services / Medical Record Department).

Firma del Paciente o representante legal	Fecha
Si firma el representante legal, Aclarar su relación con el paciente	Firma de Testigo (opcional)

ADULT HEALTH MAINTENANCE CHECKLIST

Name: _____ D.O.B. _____

Age: _____ Sex: Male Female MR# _____

Immunizations current: Yes No (See Immunization list below) TB Risk: Yes No (Every Periodic Physical Examination)

Advanced Directive discussed: Yes No Date Discussed:

Examination & Tests	Age Range	Frequency	DATE DONE	DATE DONE	DATE DONE
INITIAL HEALTH ASSESSMENT	18 yrs. and older	Within 120 days of effective date with Plan or effective date with the PCP. May be requested from Previous PCP if done within last year.			
IHEBA/"Staying Healthy"	18 yrs and Older	Within 120 days of effective date with Plan or effective date with the PCP. Reviewed at every Periodic Health Evaluation and re-administered every 3-5 years.	Record on Staying Healthy Form.		
Check-Up Visit	18 yrs. and older	Every 1-3 years			
	Age > 65	Annually			
Cholesterol	Male, 35 yrs. and older	Every 5 years			
	Female, 45 yrs. and older	Every 5 years			
Diabetes Mellitus Screening	As risk factors indicate	PRN			
Urinalysis	65 yrs. and older	PRN			
Breast Exam	Age > 40 yrs.	Annually			
Mammography	50-74 yrs.	Every 2 years			
Pelvic Exam	19-39 yrs.	Every 1-3 yrs.			
	40 and older	Annually			
Pap Smear	Onset of sexual activity or 21-65 yrs.	Every 1 to 3 yrs. At 65 discontinue routine screening if previous screenings negative. Discontinue at age 70 unless clinically indicated.			
Chlamydia	< age 25, all sexually active non-pregnant women > age 25, as risk factors indicate				
Bone Density	65 yrs. and older	At least once			
Vitamin D Deficiency	65 yrs. and older	At clinician's discretion			
TSH Screening	40 yrs. and older	Every 5 years			
High Sensitivity Fecal Occult Blood	50-75 yrs., 76-85 at clinician's discretion 86 and Older Do not screen	Annually unless clinically necessary			
Sigmoidoscopy	50-75 yrs., 76-85 at clinician's discretion 86 and Older Do not screen	5 yrs.With High Sensitivity Fecal Occult Blood every 3 years unless clinically necessary			
Colonoscopy	50-75 yrs., 76-85 at clinician's discretion 86 and Older Do not screen unless clinically necessary	Every 10 years			
Prostate Exam	Physician discretion and as clinically indicated	PRN			
PSA	50 and older or as clinically indicated	PRN			
Adult Immunizations					
Tetanus-Diptheria-Pertussis(Tdap)	18 yrs. and older	1 dose only			
HPV	Females, 18-26 yrs. (HPV2 or HPV4) Males, 18-26 yrs (HPV 4)	3 doses			
Varicella	18 yrs. and older	2 doses if no evidence of immunity			
Zoster	60 yrs. and older	1 dose			
MMR	Born 1957 or after Born before 1957	1-2 doses unless immunity documented Considered immune, unless documentation of immunity required			
Influenza	18 yrs. and older	Annually			
Pneumococcal	18 yrs. and older	1-2 doses, when clinically indicated			
Hepatitis A	18 yrs. and older	2 doses			
Hepatitis B	18 yrs. and older	3 doses			
Meningococcal	18 yrs. and older	1 dose, 2nd dose if high risk			

PCP	Page 1 of 1
Section: Office Management	
POLICY AND PROCEDURE: Provision of Services 24 Hours a Day	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised By:_____ Revised By:_____

POLICY:

The site will have a provision for appropriate, coordinated health care services twenty-four hours a day, seven days a week

PROCEDURE:

A. The staff will ensure that current clinic office hours are posted within the office or readily available upon request.

B. The PCP will ensure that current site-specific resource information is available to site personnel about physician office hour schedule(s), local and/or Plan-specific systems for after-hours urgent care, emergent physician coverage available 24 hours a day, 7 days per week, and system for providing follow-up care.

C. The staff will be able to contact the PCP (or covering physician) at all times via telephone, cell phone or pager.

AFTER HOURS SAMPLE SCRIPT

One of the following scripts may be used by your medical group as a template for ensuring members have access to timely medical care after normal business hours.

IMPORTANT: Effective telephone service after normal business hours providers for callers to reach a live voice or answering machine within 45 seconds.

I. CALLS ANSWERED BY A LIVE VOICE (E.G. ANSWERING SERVICE OR CENTRALIZED TRIAGE):

If the caller believes the situation is an emergency, advise the caller to call 911 immediately.

If the caller believes the situation is an emergency, advice the caller to call 911 immediately or proceed to the nearest Emergency Room or Urgent Care Center. Give the address of the Emergency Room or Urgent Care.

If the member indicates a need to speak with a physician, facilitate the contact with the physician by:

a) Putting the caller on hold momentarily and then connecting the caller the on-call physician, or
b) Get the members number and advise a physician will call them back within the hour, or
c) Giving the caller the pager number for the on-call physician and advising them to call back if they have not heard from the physician within one hour.
d) If a member indicates a need for interpreter services, facilitate the contact by accessing interpreter services.

II. CALLS ANSWERED BY AN ANSWERING MACHINE

If this is an emergency, please hang up and call 911immedicatly.

Hello, you have reached (Name of the Doctor/Medical Group). If you wish to speak with the physician on-call,

a) Please hold and you will be connected to (dr.name)
b) You may reach the on-call doctor directly by calling/.
c) Please call/. The doctor will be paged and you may expect a return call within one hour.
   If you do not hear from the doctor within one hour, please go to the Urgent Care Center or the nearest Emergency Room if an Urgent Care Center is not available.
d) Our urgent Care Center is located at /*.

   [Appropriate language options should be provided for the location.]

EJEMPLO DE GUION PARA DESPUES DEL HORARIO DE ATENCION MEDICA

Cualquiera de los siguentes guiones puede ser utilizado como guia por su grupo medico, para asegurarse de que los miembros reciban atencion medica oportuna despues del horario normal de atencion.

IMPORATNTE: El servicio telefonico efectivo despues del horario normal de atencion hace posible que las personas que llaman , se comuniquen con una persona o con un contestador automatico dentro en un lapso de 45 segundos.

I. LLAMADAS RESPONDIDAS POR EL PERSONAL (POR EJEMPLO, POR UN SERVICIO DE ATENCION DE LLAMADAS O DE GUARDIAS CENTRALIZADAS):

Si la persona que llama cree que la situacion constituye una emergencia, aconsejele que llame al 911 immediatamente.

Si la persona que llama cree que la situacion puede ser de emergencia o es urgent, aconsejele que llame al 911 inmediatamente o que acuda a la sala de emergencias o al centro de atencion de urgencias mas cercanos. Proporcionele la direccion de la sala de emergencia o del centro de atencion de urgencias.
;
Si el miembro le idica la necesidad de hablar con un medico, facilitele el contacto con el medico, de la siguiente manera:

a) Coloque a la persona que llama momentaneamente en espera y luego comuniquela con el medico de guardia o,
b) Obtenga el numero telefonico del miembro e indiquele que un medico le llamara en el lapso de una hora o,
c) Proporcionele a la persona que llama el numero del localizador del medico de guardia y aconsejele qye vuelva a llamar si no ha tenido noticias del medico en el lapso de una hora.
d) Si el miembro le indica que necesita los servicios de un interprete ,facilitele la comunicacion, accediendo a los servicios de interpretacion.

II. LLAMADAS RESPONDIDAS POR UN CONTESTADOR AUTOMATICO:

Si es una emergencia, por favor cuelgue y llame imediatamente al 911.

Hola, usted se a comunicado con (nombre del medico/ Grupo medico). Si desea hablar con el medico de guardia:

a) Por Favor, espere y sera comunicado con el Dr. (nombre)
b) Usted Puede comunicarse directamente con el medico de guardia llamando al/.
c) Por favor, llame al /. El medico recibira el mensaje en su localizador y usted debera esperar la llamada del medico, que se producria en el lapso de una hora.Si no recibe noticias del medico dentro de dicho plazo por favor acuda a la sala de emergencias o al centro de atencion de urgencias disponible,
d) Nuestra sala de emergencias o el centro se atencion de urgencias se encuentra ubicado en /*.

[Para la ubicacion deben porporcionarse las opciones adecuadas de idiomas]

PCP	Page 1 of 2
Section: Office Management	
POLICY AND PROCEDURE: Appointments and Patient Recall	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:_____

POLICY:

A system is established that provides timely access to appointments for routine care, urgent care, prenatal care, pediatric periodic health assessments/immunizations, adult initial health assessments, specialty care and emergency care.

PROCEDURE:

A. Staff shall notify and remind members of scheduled appointments and/or preventive screening appointments.

B. The PCP will provide an initial health assessment for each adult member within 120 days of the date of enrollment and within 60 days for the pediatric member 18 months and under, unless the member's PCP determine that the member's medical record contains complete and current information consistent with the assessment requirements within periodicity time requirements.

C. The Health Plan will follow its procedure to advise the plan members of the availability and value of scheduling an IHA appointment. The Health Plan will provide monthly eligibility reports to PCPs, listing the member's names, addresses, and telephone numbers. If a member or guardian refuses to have an IHA performed, this information must be documented in the member's medical record.

D. Staff will follow up on missed and/or canceled appointments via mail or phone. At least two attempts to reach the patient will be made and documented in the patient's record.

E. Appointment Rescheduling - When it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice, and consistent with the objectives of this policy.

F. The PCP will ensure that appointments are designed according to the patient's clinical needs and within the following timeliness standards:

1. Urgent Care: within 48 hours
2. Prenatal Care: within 10 business days
3. Non-urgent Care: within 10 business days
4. Well child Visits: within 14 days
5. Specialty Care within 14 days

Section: Office Management	
POLICY AND PROCEDURE: Individual Health Education Behavioral Assessment (Staying Healthy Assessment Tool)	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:_____

POLICY:

The "Individual Health Education Behavioral Assessment (IHEBA)" form (also known as Staying Healthy Assessment) will be completed for all Medi-Cal managed care within 120 days of enrollment or within 60 days of enrollment if 18 months or younger as part of their Initial Health Assessment. The assessment will provide dialogue between the provider and patient/parent/guardian, identify health education needs, and document effective and appropriate interventions, referrals and follow up. This is a State Department of Health Care Services requirement under the Medi-Cal Managed Care contract.

PROCEDURE:

Staff will obtain "Individual Health Education Behavioral Assessment (IHEBA)" forms in the appropriate age and language. Forms are available from Blue Shield of CA Promise Health Plan web site or can be downloaded from the Department Of Health Care Services at:

https://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthyAssessmentQuestionnaires.aspx

A. Office staff will give the age and language appropriate form to the patient or legal guardian to complete while waiting for their visit and offer assistance in completion of the form if needed. Staff will inform the patient/legal guardian that completing this form is voluntary and will help their doctor understand their health education needs**. Staff will have the patient or legal guardian document the refusal directly on the assessment form on the Page 2 at the bottom of the page by checking the box Patient Declined the SHA and Sign, print name and date the age appropriate form in the comments section above the decline box each year they decline the SHA.**

1. The nine age appropriate tools are as follows:

   0-6 Months
   7-12 Months
   1-2 Years
   3-4 Years
   4-8 years
   9-11 years
   12-17 years
   Adult
   Senior

B. The physician will review the responses in the 3rd, 4th and 5th columns of the "IHEBA" with the patient. The physician will provide the appropriate intervention(s) and document the code in the far right column. The Physician will document the interventions in the Clinic Use only. The intervention codes can be found at the bottom of the form. The physician will sign the form at the bottom page 2.

C. The form will be filed in the patient's medical record. The adolescent (12-17 years) form must be protected under confidentiality requirements .i.e. cannot be disclosed to the parent or any other person without the adolescent's written permission.

D. The physician will review the "IHEBA" form at subsequent visits, or at least annually for ages 1year through Senior and provide indicated additional counseling and follow-up.

E. The assessment is re-administered according to the following schedule:

Questionnaire	Administer	Administer-Re-administer	Review	
Age Groups	Within 120 Days of Enrollment	1st Scheduled Exam (after entering new age group)	Every 3-Years	Annual(Interval Years)
0-6mo	X			
7-12 mo	X	X		
1-2 yrs	X	X		X
3-4 yrs	X	X		X
5-8 yrs	X	X		X
9-11 yrs	X	X		X
12-17 yrs	X	X		X
Adult	X		X	X
Senior	X		X	X

F. When a member answers "yes" to the SHA alcohol pre screen question 19 on the adult form or question 23 on the senior form the physician or other qualified practitioner must implement the Screening, Brief Intervention and Referral to treatment (SBIRT) process mandated by the Department Of Health Services (Plan Letter 14-004.)

1. The Provider must offer the member and expanded, validated alcohol screening questionnaire. While any validated screening tool is acceptable, DHCS recommends the use of the Alcohol Use Disorder Identification Test (AUDIT) or Alcohol Use Disorders Identification Test-Consumption (AUDIT-C).

2. Providers will offer brief Intervention(s) to those members that a provider identifies as having risky or hazardous alcohol use when a member responds affirmatively to the alcohol question in the SHA, provides responses on the expanded screening that indicate hazardous use, or when otherwise identified. Brief interventions typically include three sessions, 15 minutes in duration per session, offered in-person, by the telephone, or telehealth modalities.

Attachments: Locating SHA forms, SHA Training Sign In Sheet, SHA form

Locating SHA Forms

Dear Doctor,

You and your staff can obtain the Staying Healthy Assessment Forms in any of the threshold languages from one of two sources:

Blue Shield of CA Promise Health Plan: Located on the Blue Shield of CA Promise website:

https://www.blueshieldca.com/promise/providers/index.asp?secProviders=quality-improvement

- Under **Initial Health Assessment (IHA)**, click on: "**IHA Guidelines & Resources**"

- Scroll down to **Staying Healthy Assessment (SHA)**

Department of Health Care Services: Located on DHCS website:

https://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthyAssessmentQuestionnaires.aspx

Provider training: http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx

STAYING HEALTHY ASSESMENT TRAINING SIGN IN SHEET

Provider Name		
Address		
City,State,Zip		
Date Of Training		
Print Trainer Name		☐ Slide Presentation
HEALTH PLAN		

CONTENT OF TRAINING (Check the boxes that apply)

- ☐ State Training Slide Presentation
- ☐ Review of actual form(s) for specific questions following slide presentation
- ☐ Review of Provider Office Instruction Sheet
- ☐ Review of SHA Revision Summary Sheet

Sample forms for different ages and languages:
http://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthyAssessmentQuestionnaires.aspx

Provider training: http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx

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Print First Name	Print Last Name	Signature	Title	Trainer Initials

Note: Use Second sheet if necessary and both sheets must b e turned in with office demographics completed.

STAYING HEALTHY ASSESSMENT (SHA)

Instruction Sheet for the Provider Office

Questionnaire	Administer	Administer/Re-administer		Review
Age Groups	Within 120 Days of Enrollment	1st Scheduled Exam *(after entering new age group)*	Every 3-5 Years	Annually *(Interval Years)*
0-6 mo.	√			
7-12 mo.	√	√		
1-2 yrs.	√	√		√
3-4 yrs.	√	√		√
5-8 yrs.	√	√		√
9-11 yrs.	√	√		√
12-17 yrs.	√	√		√
Adult	√		√	√
Senior	√		√	√

SHA Recommendations

12-17 Years Age Group

- Annual re-administration is recommended due to rapidly changing risk factors for this age group.
- Adolescents should complete the SHA on their own at the earliest age possible. PCP and Parent/guardian will determine the appropriate age based on cultural/community norms and values.

Adult and Senior Groups

- Generally, the "Adult" questionnaire should be completed by all 18-55 year old patients.
- After 55 years of age, PCP needs to select the assessment (Adult or Senior) best suited for patient based on health status, biological age, chronic conditions, mobility, etc.

SHA COMPLETION

- Explain the SHA's purpose and how it will be used by the PCP.
- Provide assistance and/or translation services if needed.
- Assure patient that SHA responses are confidential and will be kept in patient's medical record.
- A parent/guardian must complete the SHA for children under 12.
- Have the patient self-complete the SHA in a waiting room or exam room prior to the exam. *Patients tend to answer sensitive questions more honestly when self-completing the SHA.*
  - Optional: SHA questions may be asked verbally and patient responses recorded directly in patient's electronic medical record.

PATIENT REFUSAL TO COMPLETE THE SHA

- How to document the refusal on the SHA:
  1) Enter the patient's name and date "today's date" on first page
  2) Check the box "Patient Refused to Complete SHA" (back page)
  3) PCP must sign, print name and date the back page
- Patients who previously refused to complete the SHA should be encouraged to complete an age appropriate SHA every subsequent year during a scheduled exam.
- PCP must sign, print name and date an age appropriate SHA each year verifying that the patient continues to refuse to complete the SHA.

PCP REVIEW

- PCP must review completed SHA with patient. Other clinic staff may assist as long as medical issues are referred to the PCP.
- If SHA responses indicate risk factors (checkboxes in the middle column), the PCP should explore patient responses to verify risk factors and determine extent to which they may be harming patient's health.
- Tailored health education counseling, referral, anticipatory guidance materials, and follow-up must be provided based on SHA responses.

REQUIRED PCP DOCUMENTATION

- PCP must sign, print name and date the newly administered SHA to verify it was reviewed with patient and assistance/follow-up was provided as needed.
- PCP must check appropriate boxes in "For Clinical Use Only" section to indicate topics and assistance provided to patient (back page).
- For subsequent annual reviews, PCP must sign, print name and date "SHA Annual Review" section (back page) to verify the annual review was conducted with the patient.
- Signed SHA must be kept in patient's medical record.

OPTIONAL DOCUMENTATION

- Shaded "Clinic Use Only" sections (front & back page) and "Comments" section (back page) may be used to take notes about patient discussion and recommendations.

Staying Healthy Assessment FAQs

The Staying Healthy Assessment (SHA) and IHEBA (Individual Health Education Behavioral Assessment) requirements are included in MMCD's Policy Letter 13-001 (Revised) http://www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx. SHA FAQs include questions from Medi-Cal managed care health plans (MCPs) and their providers/provider groups. Responses to these questions are intended to provide additional clarification regarding SHA and IHEBA requirements.

SHA IMPLEMENTATION

1. Notification - SHA Electronic and Alternate Format

   Are Medi-Cal managed care health plans (MCPs) still required to notify MMCD one month in advance if a provider/provider group is planning the use the SHA (questions) in an electronic or alternate format?

   No. MCPs are no longer required to notify MMCD when a provider/provider group plans to use the SHA in an alternate format (electronic or other paper based format), as long as the provider/provider group:

   - Uses all SHA questions for the specific age group,
   - Uses the most current version available on the SHA Webpage, and
   - Informs their contracted health plan *at least one month before* they plan to implement the SHA in an electronic or alternative format.

   *Publication in the SHA FAQs serves as official notification of the change in this requirement.

2. SHA Documentation

   Does an "MD" need to sign the SHA form for documentation purposes or can a Nurse Practitioner and/or Physician Assistant sign if they were the one who saw the patient and reviewed the questionnaire?

   Since Nurse Practitioners and Physician Assistants are PCPs, they can also sign the form.

3. SHA Documentation

   Some providers are reluctant to sign the SHA if they are unable to thoroughly discuss/counsel and provide anticipatory guidance, referral, or follow-up on each behavioral risk identified during the administration of the SHA. Many patients have multiple behavioral risks that require follow-up. We suggested making a follow up visit, but it is difficult for these members to return for a follow-up appointment. How should I advise our providers?

   Providers will not be out of compliance if they prioritize and address the most urgent behavioral risk(s) during the administration of the SHA. On the SHA form, providers should note which risks they were able to address during the SHA administration, and note that other behavioral risks will be addressed during subsequent office visits. Even if it is difficult for these members to return for a follow-up appointment, providers will not be out of compliance if they prioritize and address the most urgent issues first.

4. SHA Implementation Deadline

   Some providers were unable to complete the Staying Healthy Assessments for all new Medi-Cal enrollees before the April 1 deadline. Is there any flexibility in meeting this deadline?

   Plans were **not** expected to complete Staying Healthy Assessments (SHA) for all Members by the April 1, 2014 deadline. By April 1, providers needed to be trained and prepared to administer the SHA per MMCD PL 13-001 as follows:

   - For new Members: the SHA and Initial Health Assessment (IHA) must be administered/completed within 120 days of enrollment.
   - For established patients without a completed SHA/IHEBA: The SHA must be administered during a non-acute, scheduled office visit (e.g., check-up or wellness visit) following the April 1 deadline.

5. Additional SHA Languages Needed

   Some providers treat patients who speak non-threshold languages which makes administering the SHA very time consuming. Are there plans to add more languages?

Staying Healthy Assessment FAQs

Currently, the SHA questionnaires are available in the state's threshold languages, as well as Somali. With the expansion of the Affordable Care Act, there may be more threshold languages in the future. In the meantime, MCPs may translate the SHA into other languages which we will make available. Please check the website from time to time to see if more languages have been added or check with your MCP (some languages are not immediately available online due to accessibility requirements).

6. Billing for the SHA

Pediatricians have asked about the CPT code for the SHA on the PM160? Is there a specific place in the form?

For providers who are not paid a capitated rate by the MCP, the SHA would be included in the billing for the Initial Health Assessment and/or annual wellness care. Providers should contact their MCP for information about billing.

7. SHA Review/Re-Assessment

If a member makes lots of changes to their previous responses on the SHA form, should the member be asked to complete new form?

It is up to each provider to determine what would work best to keep track of the member's behavioral risks. Completing a new SHA is not a requirement unless the member has entered a new age group.

8. D-SNP Medi-Cal FFS Eligibles

Do the policy letter SHA requirements for MCPs apply to Medicare Advantage plans offering a D-SNP (dual eligibles special needs plan) under contract to DHCS if the plan does not offer a Medi-Cal Managed Care Plan (i.e., the member's Medi-Cal coverage is FFS & not through an HMO)?

The SHA requirements do not apply to their D-SNP members. It only applies to those enrolled in Medi-Cal managed care plans.

9. Tracking SHA Administration

What does the State expect the MCPs to do regarding tracking and ensuring members complete the SHA, as required? Is it through audits or some means of actually tracking every SHA?

The goal should be to find out if providers are implementing the SHA as required; MMCD is not expecting the MCPs or IPA to track individual members to verify the SHA was completed. After providers are trained on the SHA, MCPs should provide follow-up and assistance to providers that are not implementing the SHA or having difficulty implementing the SHA as required. MCPs should promote the use of the SHA and work with providers to identify and address barriers in complying with SHA/IHEBAS requirements.

10. SHA Compliance

How does the State determine if the MCP's are in compliance with SHA requirements? Are the SHA requirements included in the MCPs contract with the State? Does the State audit for this requirement?

During the medical record review portion of Facility Site Reviews (FSR), nurses review medical records for evidence that the IHA and SHA/IHEBA were completed according to guidelines. FSRs are conducted by the MCP and by MMCD.

11. SHA Questions and Health Literacy

Have the pediatric SHA questions been validated as a screening tool for issues in nutrition, safety, mental health, development, etc., with culturally and linguistically diverse populations, including those with relatively low health literacy and low literacy?

The SHA was developed by a committee of about 50 health plan representatives, including doctors, nurses and health educators. The questions/topics were taken from recommendations from a various professional sources, such as the U.S. Preventive Services Task Force Recommendations, American Academy of Pediatrics, etc. The committee made sure that each question was stated in the simplest way possible to accommodate members with low literacy skills. MMCD surveyed providers and interviewed members to ensure that the questions were understood in English and Spanish. We did not have the resources to pilot test the questions with any of the other language groups.

Staying Healthy Assessment FAQs

12. SHA Resources/References

What resources/references were used in the development of SHA questions?

Many professional and governmental sources were used in the development of the SHA questions. MMCD will be adding the references that were used for all SHA questions to the webpage.

13. Availability of SHA Electronic Format

Are the SHA questions available in an electronic format that could be used in an electronic health record system such as EPIC?

They are not currently available in an electronic medical record system. DHCS is exploring the possibility of making the SHA and other DHCS required forms available in an electronic medical record system.

14. Using the SHA Instead of Validated Screening Tools

Many providers currently use a variety of validated screening questionnaires (e.g., ASQ, PHQ-9, SEEK, CEASE Tobacco Exposure questionnaire) and want to know if they should consider discontinue using them in lieu of SHA requirements. How sensitive is the SHA in screening for the morbidities affecting the Medi-Cal population?

All questions about the use of the SHA versus other assessment tools should be discussed between the provider and the MCP. The SHA is a *behavioral assessment* and is not intended to replace clinical screenings or assessments. The SHA meets Title 22 requirements regarding the use of a behavior risk assessment to identify and address health education needs for MCP members.

15. Confusion Regarding SHA and Other Screening Tools

We are a new provider and we are confused about all the SHA requirements, CHDP requirements, the Initial Health Assessment, and other Screening tools/questionnaires that we should be using. Can you please help us?

Please contact your MCP for assistance and clarification on Medi-Cal manage care requirements. The MCP is responsible to providing training and assistance on these requirements.

Only Primary Care Providers (PCPs) are required to administer the SHA, as part of the IHA and during regular ongoing wellness care visits. Providers who are not PCPs are not required to administer the SHA.

16. SHA documentation

Is it OK to stamp, “See Chart” in the “Clinic Use Only” section at the end of the form, instead of checking the boxes (topics and services provided)? What about when the provider is planning to scan the SHA into the medical record after it is completed by the member?

If the provider is going to scan the completed SHA form, we recommend checking the boxes in the Clinic Use Only section and adding the PCP’s signature before it is scanned. Additional progress notes are not required on the form, and can be kept in the medical record.

17. Reviewing/Re-Administering the SHA Electronically

Is there a way to complete the SHA form electronically after first administration so it doesn’t have to be printed, signed, and rescanned?

Without the appropriate software, it is difficult to update a scanned form electronically. An alternative would be to use the PDF fillable/writable form. All SHA forms are available in a PDF fillable/writable version from your MCP.

18. SHA Provider Training Requirements

What are the MCP requirements regarding SHA provider training?

It is the responsibility of the MCP to ensure that their providers are trained on how to use the SHA. MCPs must keep documentation identifying names and dates of when their providers were trained. The narrated SHA PowerPoint training can be viewed by individual providers or used by MCPs for training. The training is available on the SHA web page: http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx#. The narrated PowerPoint takes about 20 minutes to complete.

19. SHA Provider Training Attestation

Does the State have specific requirements or forms the MCPs should use for providers to attest they have completed the SHA training?

No. Each MCP should develop a process that works best for their system and their providers. MCPs can create a log, sign-in sheet, or certificate to ensure they have the data required during an audit (usually date, time, name, etc.). MCPs can use the same process they use for other provider trainings.

20. SHA Periodicity

How often should the SHA be administered?

The SHA Periodicity is available on the *Provider Office Instruction Sheet* on the SHA web page: http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx#. All providers should complete the Provider Training, a narrated PowerPoint, also available on the web page. For additional assistance contact your MCP.

21. Provider Training Reimbursement

Does Medi-Cal reimburse providers for completing the SHA training?

No. Provider training is part of the capitated rate with their contracted health plan.

22. Anticipatory Guidance

Please define "anticipatory guidance" and "follow-up ordered," which are both used in Policy Letter 13-001.

"Anticipatory guidance" refers to discussing and providing age-appropriate educational materials, such as the *Growing-Up Healthy* series or the *CA Staying Healthy Tip Sheets*. "Follow-up ordered" refers to scheduling a follow-up appointment, ordering lab tests, etc. The provider should determine what, if any, follow-up is needed for each patient.

23. SHA Tip Sheets

Will DHCS be updating the SHA Tip Sheets to correlate with the new forms? If not, are there other educational handouts available that are associated with the new/revised SHA?

MMCD, in collaboration with staff from the MCPs, has begun to work on updating the SHA Tip Sheets. After they are completed and translated, they will be posted on the SHA webpage. For now, MMCD and the MCPs suggest using CHDP's *Growing Up Healthy* brochures. The CHDP brochures are available in some threshold languages on the CHDP website: http://www.dhcs.ca.gov/formsandpubs/publications/Pages/CHDPPubs.aspx.

24. SHA Provider Counseling Resource Guide

Is DHCS planning to update the *Provider Counseling Resource Guide* that was available on the DHCS web site many years ago? If not, does DHCS have other resources providers can use to counsel members about specific risk factors?

No. The *Provider Counseling Resource Guide* will not be updated. Instead, MMCD is planning to post links to provider resources that will include: USPSTF A and B Recommendations, health education and SHA topic specific resources, cultural and linguistic resources, provider training resources/webinars, etc.

SHA FORMS/QUESTIONNAIRES

25. SHA Questionnaire Corrections

We have received emails regarding updated/corrected versions of the SHA form, but all the forms on the SHA web page have the same date, "Rev 12/13." How can I determine which are the correct revised forms?

Because the content of the SHA questionnaires has not changed, the revision date was kept the same. The revision date on the questionnaires will be updated when there is an update to the content. We do not anticipate making any other changes to the questionnaires until the SHA content is updated. MMCD will always notify the MCPs when any updates are made to the SHA.

26. SHA Questionnaire Updates

How often and how will the SHA questionnaires be updated to ensure that they do not become outdated again?

MMCD is developing a process to regularly update the SHA questionnaires. A SHA committee will be created to advise the department on this process. Due to the challenges in updating the SHA in all threshold languages, we do not anticipate making changes or updating the questionnaires more than once per year. MCPs and providers can send emails regarding updates/changes to MMCDHealthEducationMailbox@dhcs.ca.gov. MMCD will compile all recommendations for the SHA committee to review. DHCS and the SHA committee will be responsible for regularly updating the SHA questionnaires to ensure that they reflect preventive care guidelines.

27. SHA 7-12 months-Question #2

Since cow's milk is not recommended for children under 1 year of age, should the question about 3 servings of calcium-rich foods include the term 'milk' for the 7-12 month age group?

All comments and feedback about the content of the questions will be shared with the SHA committee, who will be tasked with making recommendations regarding changing/updating SHA questions.

28. SHA 12-17 years, Question #35

As a pediatrician and an advocate for LGB youth, I find question #35, "Do you have concerns about liking someone of the same sex." inappropriate. While I believe it is important to identify LGBT youth who may be at risk for adverse health outcomes, and applaud the effort, the phrasing of the question may imply there is something wrong with like someone of the same sex. Would it be possible to substitute the current wording with the following? "Do you have any concerns about your sexuality or sexual orientation?"

Thank you for your suggestion. We have shared your concern and suggestion with the SHA Committee and they have decided to pilot test various versions of this question. In the meantime, you can replace the current wording for question #35 with your suggestion, *"Do you have any concerns about your sexuality or sexual orientation?"* Please contact your contracted health plan for assistance in making this specific change. If you decide to replace question #35 (SHA 12-17 years) you will need to revise and update any SHA translations that you administer to your members.

SBIRT

29. SHA and SBIRT Assessment Requirements

If an adult member answers "Yes" to the SHA alcohol question, and if after reviewing the questionnaire and providing additional counseling with the member, the provider's professional opinion is that the additional assessment may not be warranted, are they still required to deliver the assessment?

No. If after discussing with the patient, the provider does not think the member is misusing alcohol, they do not have to administer the additional assessment; they should document it on the SHA or medical record. However, a validated screening tool, such as the AUDIT-C, can be a more effective way to determine and document the need for brief intervention or referral. With few exceptions, most patients who answer "yes" to the alcohol question on the SHA should receive the screening tool. DHCS will be monitoring these services.

30. Alcohol Question and Alternative IHEBA

If a provider uses Bright Futures or another approved IHEBA, how should the alcohol question/SBIRT benefits be handled?

The provider should incorporate the SHA alcohol question (adult or senior) into the administration process for the alternate assessment to ensure that the member is asked about his/her alcohol use. The member's response should be documented on the alternate IHEBA form or in the medical record. An additional validated screening tool should be administered if the member's response was "yes".

31. SBIRT Provider Training

In order to do the SBIRT training, do you have to do 4 hours of training or just 1 hour? Our MCP is saying only 1 hour is required. Also, will reading through the PowerPoint be sufficient in doing the training? If the PowerPoint won't do, is the training free or does it cost? And can the employee do the training in 2 hour increments?

Staying Healthy Assessment FAQs

Our Medical Director has a question regarding the SBIRT Provider Training Requirement per practice. How broad is the definition of practice? Is it restricted to an individual site, or could it include a provider group practice at different locations in a region?

DHCS has an SBIRT webpage (http://www.dhcs.ca.gov/services/medi-cal/Pages/SBIRT.aspx) that includes a *New SBIRT Training* section. Webinars and trainings for PCPs and non-PCPs are available and will count towards the 4-hour SBIRT training requirement. DHCS is offering half-day in-person trainings throughout the State. Training dates and locations are listed on the SBIRT webpage (http://www.dhcs.ca.gov/services/medi-cal/Pages/SBIRTTrainingDatesandLocations.aspx) or check with your MCP to find out when training is available in your area.

For more information, here is a link to the DHCS All Plan Letter on SBIRT requirements: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-004.pdf. The PowerPoint on the SHA webpage does not count towards the SBIRT training requirements.

DHCS policy is that the non-licensed providers and at least one supervising clinician per clinic location need to take 4 hours of SBIRT training. Providers are required to attest to having taken the training; attestations should be kept in the primary care clinic and made available on request during facility site reviews.

32. Monitoring SBIRT Services

How will the state monitor the provision SBIRT services (per APL 14-004)?

DHCS will be working with MCPs and stakeholders to develop a process for monitoring the implementation of these new requirements. DHCS will communicate these reporting and monitoring requirements separately. However, MCPs are responsible for monitoring and ensuring that providers are offering SBIRT services as required.

33. Information Regarding Alcohol Misuse

Where can providers obtain the AUDIT-C form and information regarding alcohol misuse?

The forms and information are available on the DHCS SBIRT webpage: http://www.dhcs.ca.gov/services/medi-cal/Pages/SBIRT.aspx.

BRIGHT FUTURES NOTIFICATION

34. Notification Requirement

Our clinic would like to use AAP's Bright Futures instead of the SHA? How should we notify DHCS of our intent to use Bright Futures?

When a provider/provider group wants to use Bright Futures instead of the SHA, the MCP is responsible for notifying MMCD one month in advance. The notification must include information about the method/process to document its use, administration, annual review, and follow-up. Notification must also include the age groups and questionnaires that will be used. If Bright Futures is used for 18-21 year olds, the alcohol question on the Adult SHA must be added to Bright Futures, or other form, that will be administered on a yearly basis. MMCD and some MCPs have developed a Bright Futures notification form. Please contact your MCP to get instructions on what you need to submit to your MCP to begin the process.

35. Bright Futures/Required Questionnaires

We are planning to use Bright Futures, instead of the SHA. There are so many questionnaires for Bright Futures; we want to know which forms are required to satisfy the IHEBA requirement?

If you plan to use Bright Futures to satisfy the IHEBA requirement, you must administer the following forms:

- Age specific Pre-visit Questionnaires
- Age specific Supplemental Questionnaires
- For adolescents (11-21 years), the provider must administer new Pre-visit and Supplemental Questionnaires every year (even if the member has not changed age groups).

Staying Healthy Assessment FAQs

If Bright Futures is used for 18-21 year olds, the SBIRT question on the Adult SHA must be added to one of the questionnaires, or other form, that is administered annually. Otherwise, the SHA should be administered to members ages 18-21.

36. Adolescent Age Range Discrepancy

Why does Bright Futures and CHDP age range for adolescents include 18 to 21 year olds, while the SHA defines 18 to 21 year olds as adults?

The U.S. Preventive Services Task Force (USPSTF) defines "Adults" as **18 years and older**. MCPs are required to offer/cover all USPSTF, A and B recommended services to all their members, so the SHA is consistent with the USPSTF definition/age range for adolescent and adults.

ALTERNATIVE IHEBA REQUEST

37. Alternative IHEBA Requests

Instead of the SHA, our clinic providers would like to use an alternative IHEBA they developed for their patients. What is the process for getting approval to use an alternative IHEBA?

You should contact your MCP to let them know that your clinic would like to use an alternative IHEBA. Your MCP will review your clinic's alternative IHEBA to determine if it meets the minimum requirements for MMCD approval. The MCP will ask you for specific information so they can submit the required documentation request form to the state. An alternative IHEBA, at a minimum, must be comparable to the SHA with respect to risk factors and periodicity. The MCP must submit the following information to MMCD for approval of an alternative IHEBA:

- Providers/provider groups who will be using the alternative IHEBA
- Name of the IHEBA/organization who developed the alternative IHEBA
- The purpose or intent of the development of the IHEBA
- Age groups that will use the alternative IHEBA (with a copy of each age specific assessment)
- A crosswalk comparing the SHA questions/risk factors with the alternative IHEBA
- Explanation of the administration and documentation process for administering the assessment, including the annual review, if appropriate.

PCP	Page 1 of 2
Section: Office Management	
POLICY AND PROCEDURE: Triage	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:_____

POLICY:
The site shall have sufficient health care personnel to provide timely, appropriate health care services. Triage is the sorting and classification of information to determine priority of need and proper place of treatment. Telephone triage is the system for managing telephone callers during and after office hours.

PROCEDURE:

A. The PCP will ensure that appropriate personnel handle emergent, urgent and medical advice telephone calls. This includes licensed medical personnel such as a CNM, NP, RN or PA. LVN's cannot perform triage independently (MCPB letter 92-15). LVNs and unlicensed personnel such as medical assistants may provide patient information or instructions only as authorized by the physician (Title 16, 1366b)

B. Staff will ensure that a telephone answering machine, voice mail system or answering service is utilized whenever office staff does not directly answer phone calls.

- The practitioner is responsible for the answering service it uses. If a member calls after hours or on a weekend for a possible medical emergency, the practitioner is held liable for authorization of or referral to, emergency care given by the answering service. There must be a message immediately stating, "If this is an emergency, hang up and call 911 or go to the nearest emergency room."
- Answering service staff handling member calls cannot provide telephone medical advice if they are not a licensed, certified or registered health care professional. Staff members may ask questions on behalf of a licensed professional in order to help ascertain the condition of the member so that the member can be referred to licensed staff; however, they are not permitted, under any circumstance, to use the answers to questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of the member, or to determine when a member needs to be seen by a licensed medical professional.

Unlicensed telephone staff should have clear instructions on the parameters relating to the use of answers in assisting a licensed provider.

C. Staff will ensure that the telephone system, answering service, recorded telephone information, and recording devices are periodically checked and updated (see suggested scripts as seen in section 18 of this manual).

- Health Plans encourage answering services follow these steps when receiving a call:
  - Inform the member that if they are experiencing a medical emergency, they should hang up and call 911 or proceed to the nearest emergency medical facility.
  - Question the member according to the PCP's or PPG's established instructions (who, what, when, and where) to assess the nature and extent of the problem.
  - Contact the on-call physician with the facts as stated by the member.
  - After office hours, physicians are required to return telephone calls and pages within 30 minutes. If an on-call physician cannot be reached, direct the member to a medical facility where emergency or urgent care treatment can be given. This is considered authorization, which is binding and cannot be retracted.

PCP	Page 1 of 3
Section: Clinical Services	
POLICY AND PROCEDURES: Laboratory Services	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:_____

POLICY:

The site will operate in compliance with Clinical Laboratory Improvement Amendment (CLIA) regulations. Therefore, the site shall meet all quality standards to ensure accuracy, reliability and timeliness of patient test results. All lab results are to be communicated to the provider and member in a timely manner.

PROCEDURE:

A.Laboratory test procedures are performed according to current site-Specific CLIA certificate.

1. All sites that perform laboratory testing for human health assessment, diagnosis, prevention, or treatment of disease, have a current, unrevoked, unsuspended site-specific Clinical Laboratory Improvement Amendment (CLIA) certificate, or evidence of renewal.

- The CLIA Certificate on site includes one of the following:

a. Certificate of Waiver: Site is able to perform only exempt waived tests, so therefore, has a current CLIA Certificate or Waiver. The current listing of waived tests may be obtained at https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm

- There are no specific CLIA regulations regarding the performance of waived tests. Therefore, site personnel are expected to follow the manufacturer's instructions.
- Laboratories with Certificates of Waiver may not be routinely inspected by DHCS Laboratory Field Services Division, but may be inspected as part of complaint investigations and/or on a random basis to determine whether only waived tests are being performed
- b. Certificate for Provider-Performed Microscopy (PPM): Physicians, dentists or mid-level practitioners are able to perform PPM procedures and waived tests.

c. Certificate of Registration: Allows moderate and/or high complexity lab testing to be conducted until compliance with CLIA regulations is determined by survey.

- For moderate and/or high complexity lab testing, the CLIA regulations list specific requirements for laboratory proficiency testing, patient test management, quality control, quality assurance, personnel and inspections.

d. Certificate of Compliance: Lab has been surveyed and found to be in compliance with all applicable CLIA requirements.

e. Certificate of Accreditation: Lab is accredited by an Accreditation organization approved by the Centers for Medicare & Medicaid Services (CMS).

2. CLIA certification/re-certification includes an evaluation every two years (or sooner, if complaint driven) by DHCS of personnel licenses/training, laboratory site inspection and demonstration of testing proficiency for moderate and high-complexity test sites.

B. Testing personnel performing clinical lab procedures have been trained.

1. Prior to testing biological specimens, personnel are appropriately trained for the type and complexity of the laboratory services performed. Personnel have demonstrated the ability to perform all testing operations reliably and to report results accurately.
2. Site personnel that perform CLIA waived tests have access to and are able to follow test manufacturer's instructions.
3. When requested, site personnel are able to provide a step-by-step verbal explanation or demonstration of test procedure and how to determine test results.
4. The required training and certification is established by legislation (CA B&P Codes, §1200-1213) for personnel performing moderate and high complexity tests. Reviewers are not expected to complete an in-depth evaluation of personnel performing moderate and high complexity tests.

C. Lab supplies are inaccessible to unauthorized persons. (e.g., vacutainers, culture swabs, test solutions) Not left in unlocked drawers/cabinets in exam rooms.

D. Lab test supplies (e.g., vacutainers, culture swabs, test solutions) are not expired. Site has procedure to check expiration date and a method to dispose of expired lab test supplies.

E. The provider will review, initial and date the original copy of each laboratory report, which is then filed in member's medical record.

****For questions regarding CLIA certification, laboratory licensing, and personnel, call CA DHCS Laboratory Field Services at (510) 873-6328**

Blood Glucose Calibration Log

Manufacturer name: _____

Date Control Conducted	Reason 1: Opened New Vial	Reason 2: Meter or Strips Not Working	Reason 3: Repeat Unexpected Blood Glucose Results	Reason 4: Dropped or Damaged Meter	Initials of staff performing control

Directions per manufacturer protocol:

1. When control is conducted for any of the above 4 reasons, document an “X” in the appropriate column(s) reason for calibration.
2. Staff member performing calibration should sign initials and date in the appropriate column
3. Always keep a copy of the manufacturer directions with this log
4. Keep logs for a period of <u>at least 3 years</u>

Blood Glucose Calibration Log

DAILY GLUCOMETER LOG

MONTH:				YEAR:			
DATE	TIME	CALIB/OK	MA SIGN	DATE	TIME	CALIB/OK	MA SIGN
1				17			
2				18			
3				19			
4				20			
5				21			
6				22			
7				23			
8				24			
9				25			
10				26			
11				27			
12				28			
13				29			
14				30			
15				31			
16							

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DAILY HEMOCUE CONTROL LOG

MONTH:				YEAR:			
DATE	TIME	CALIB/OK	MA SIGN	DATE	TIME	CALIB/OK	MA SIGN
1				17			
2				18			
3				19			
4				20			
5				21			
6				22			
7				23			
8				24			
9				25			
10				26			
11				27			
12				28			
13				29			
14				30			
15				31			
16							

Clinical Laboratory Improvement Amendments (CLIA)

How to Obtain a CLIA Certificate

When is a CLIA Certificate Required?

NOTE: Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988 establishing quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of patient test results regardless of where the test was performed. The final CLIA regulations were published in the Federal Register on February 28, 1992. The requirements are based on the complexity of the test and not the type of laboratory where the testing is performed. On January 24, 2003, the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services (CMS) published final CLIA Quality Systems laboratory regulations that became effective April, 24, 2003.

DO I NEED TO HAVE A CLIA CERTIFICATE?

CLIA requires all facilities that perform even one test, including waived tests, on "materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings" to meet certain Federal requirements. If a facility performs tests for these purposes, it is considered a laboratory under CLIA and must apply and obtain a certificate from the CLIA program that corresponds to the complexity of tests performed.

WHAT ARE THE DIFFERENT TYPES OF CLIA CERTIFICATES AND HOW LONG ARE THEY EFFECTIVE?

All types of certificates are effective for two years and the different types of certificates are:

- **Certificate of Waiver (COW):**
  Issued to a laboratory that performs only waived tests.
- **Certificate for Provider Performed Microscopy (PPM) procedures:**
  Issued to a laboratory in which a physician, midlevel practitioner or dentist performs specific microscopy procedures during the course of a patient's visit. A limited list of microscopy procedures is included under this certificate type and these are categorized as moderate complexity.
- **Certificate of Registration:**
  Issued to a laboratory to allow the laboratory to conduct nonwaived (moderate and/or high complexity) testing until the laboratory is surveyed (inspected) to determine its compliance with the CLIA regulations. Only laboratories applying for a certificate of compliance or a certificate of accreditation will receive a certificate of registration.
- **Certificate of Compliance (COC):**
  Issued to a laboratory once the State Department of Health conducts a survey (inspection) and determines that the laboratory is compliant with all applicable CLIA requirements. This type of certificate is issued to a laboratory that performs nonwaived (moderate and/or high complexity) testing.

- **Certificate of Accreditation (COA):**
  Issued to a laboratory on the basis of the laboratory's accreditation by an accreditation organization approved by CMS. This type of certificate is issued to a laboratory that performs nonwaived (moderate and/or high complexity) testing.

There are six CMS-approved accreditation organizations:
- AABB
- American Osteopathic Association (AOA)
- American Society of Histocompatibility and Immunogenetics (ASHI)
- COLA
- College of American Pathologists (CAP)
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Contact information for the above CMS-approved accreditation organizations is available on the CMS CLIA web site at www.cms.hhs.gov/clia. If you apply for accreditation by one of the CMS-approved accreditation organizations, you must also apply to CMS for a COA concurrently.

WHAT IS A WAIVED TEST?

As defined by CLIA, waived tests are categorized as "simple laboratory examinations and procedures that have an insignificant risk of an erroneous result". The Food and Drug Administration (FDA) determines the criteria for tests being simple with a low risk of error and approves manufacturer's applications for test system waiver.

HOW CAN I FIND A LIST OF WAIVED TESTS?

For a list of waived tests sorted by analyte name, visit the FDA website at http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm

For a list of waived tests sorted by the test categorization date and by the test system name, visit the FDA website at http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/testswaived.cfm.

WHERE CAN I FIND INFORMATION ABOUT TESTS CATEGORIZED AS NONWAIVED (I.E., MODERATE AND/OR HIGH COMPLEXITY)?

To determine which tests are categorized as waived or nonwaived (i.e., moderate or high complexity), refer to the lists of tests online at http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfCLIA/search.cfm.

You may also contact the local survey agency at your State Health Department for categorization information concerning tests that you may be performing in your laboratory. A list of State Agency addresses, phone numbers and contact persons is available online under the heading State Survey Agencies (CLIA Contact List) at the CMS CLIA website. If you do not have online access or have questions concerning certification, you may contact the CMS CLIA Central Office at 410-786-3531 for the address and phone number of your local State Agency.

HOW DO I APPLY FOR A CLIA CERTIFICATE?

The CLIA application (Form CMS-116) is available online at the CMS CLIA website located at the end of this brochure. Forward your completed application to the address of the local State Agency for the State in which your laboratory is located. This information is available online or you may contact the CMS CLIA Central Office.

IS THERE ANY TYPE OF LABORATORY TESTING THAT IS NOT SUBJECT TO A CLIA CERTIFICATE?

Yes, there are some testing exceptions that do not require CLIA certification.

The following **exceptions to CLIA certification** apply regardless of a laboratory's location:

- Any laboratory that only performs testing for forensic purposes;
- Research laboratories that test human specimens but do not report patient specific results for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, individual patients; or

- Laboratories certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), in which drug testing is performed that meets SAMHSA guidelines and regulations. However, a CLIA certificate is needed for all other testing conducted by a SAMHSA-certified laboratory.

ARE THERE ANY STATES THAT EXEMPT ME FROM HAVING TO APPLY FOR A CLIA CERTIFICATE?

Any laboratory located in a state that has a CMS approved laboratory program is exempt from CLIA certification. Currently, there are two states with approved programs: Washington and New York. New York has a partial exemption; therefore, if your laboratory is located in that state, contact the New York State Agency concerning your need for a CLIA certificate.

IF I HAVE MORE THAN ONE LABORATORY LOCATION, DO I NEED A CLIA CERTIFICATE FOR EACH LOCATION?

You will need a CLIA certificate for **each** location where you perform testing **unless** you qualify for one of the exceptions listed below.

- Laboratories that are not at a fixed location; that is, laboratories that move from testing site to testing site, such as mobile units providing laboratory testing, health screening fairs, or other temporary testing locations may be covered under the certificate of the designated primary site or home base, using its address.
- Not-for-profit or Federal, State or local government laboratories that engage in limited public health testing, may file a single application.
- Laboratories within a hospital that are located at contiguous buildings on the same campus and under common direction may file a single application for the laboratory sites within the same physical location or street address.

Contact your State Agency if you have questions or you are filing a single application for more than one testing site.

WHAT KIND OF FEES DO I HAVE TO PAY TO CMS FOR A CLIA CERTIFICATE?

If you apply for COW or a PPM certificate, you will pay a minimal certificate fee every two years. There are no registration or compliance fees.

If you apply for a COC, you will pay a one time minimal registration fee that covers the cost of the CLIA enrollment in addition to a compliance fee that covers the cost of the initial inspection by the State Agency. CMS will send you a Certificate of Registration. Once compliance has been determined by your inspection, you will pay a certificate fee to CMS and CMS will send you a COC. A two-year certificate cycle is then established, and you will pay a certificate fee and a compliance fee every two years. CMS will send you a COC as long as your laboratory is in compliance.

If you apply for a COA, you will pay a minimal registration fee that covers the cost of the CLIA enrollment. Once CMS receives verification from the accreditation organization that you have selected, you will pay a certificate fee and validation fee to CMS and CMS will send you a COA. A two year certificate cycle is then established and you will pay a certificate fee and a validation fee every two years. CMS will send you a COA as long as your laboratory remains compliant. You will pay survey and any other fees to the accreditation organization.

You can obtain more information concerning the amount of certificate fees from the CMS CLIA website under "CLIA Certificate Fee Schedule" or from your State Agency. For information concerning compliance (survey) fees, you may contact your State Agency or accreditation organization. These fees are based on the number and types of testing you perform and must cover the cost of the CLIA program because CLIA is entirely user fee funded.

WILL I RECEIVE AN IDENTIFYING CLIA NUMBER?

You will receive a ten-digit number on the CLIA certificate. This number will be utilized to identify and track your laboratory throughout its entire history. You should use this number when making inquiries to the State Agency and CMS about your laboratory.

WHEN CAN I BEGIN TESTING?

After you apply for your certificate, you will receive a coupon notifying you of the corresponding fee. Follow the instructions on the fee coupon for payment. After CMS receives your payment, your certificate will be mailed to you. You may begin testing once you have received your certificate containing your CLIA number. However, you need to check with your State Agency since some states have additional requirements.

WILL MY LABORATORY RECEIVE A CMS SURVEY?

Laboratories that have a COW or PPM certificate are not subject to routine surveys. However, CMS is currently conducting a project whereby a small percentage of laboratories that perform only waived testing may receive an educational visit. These visits provide helpful information to staff to help assure the quality of testing and have been extremely well received.

If your laboratory performs any nonwaived testing, the laboratory may have either a COC or COA. All laboratories with either of these certificate types must meet all nonwaived testing requirements and are subject to biennial surveys, by CMS or a CMS agent (such as a surveyor from the State Agency) or by a CMS-approved accreditation organization, if the laboratory is accredited. COA laboratories must also meet the requirements of their accreditation organization.

Additionally, a limited percentage of laboratories with a COA will receive a validation survey by CMS or a CMS agent. This is a survey performed by CMS or a CMS agent to evaluate the results of the most recent survey performed by an accreditation organization.

NOTE: If CMS or the State Agency receives a complaint against your laboratory, you may receive an unannounced on site survey, even though you only perform waived tests or PPM procedures.

IF I HAVE A CERTIFICATE FOR PPM PROCEDURES, A CERTIFICATE OF REGISTRATION, A COA OR A COC, CAN I ALSO PERFORM WAIVED TESTS?

Yes, these certificates permit laboratories to also perform waived tests.

IF I HAVE A COA OR A COC, CAN I ALSO PERFORM PPM PROCEDURES?

Yes, these certificates permit laboratories to perform PPM procedures as well as waived tests. The certificate you obtain should be for the highest (most complex) category of testing you perform.

DO I NEED TO NOTIFY ANYONE IF I MAKE ANY CHANGES IN MY LABORATORY?

For **all** types of CLIA certification, you must notify the State Agency or your accreditation organization within 30 days of any changes in:

- Ownership
- Name
- Location
- Director
- Technical supervisor (for high complexity testing only)

If you perform only waived tests and wish to add PPM procedures or other nonwaived (moderate or high complexity) testing to your menu, you must reapply for the appropriate certificate using the same form (Form CMS-116) you used for your initial CLIA certification. However, you cannot begin nonwaived testing until you have paid the appropriate fee, and have received the appropriate certificate.

If you perform PPM procedures and wish to add other nonwaived (moderate or high complexity) testing, you must first apply for the appropriate certificate.

If you have a COC or COA and wish to add tests categorized under a different laboratory specialty or subspecialty than those on your current certificate or that employ a different test method from those you are already performing, you must notify the State Agency or the accreditation organization of the new testing.

IF I HAVE ANY QUESTIONS ABOUT MY CERTIFICATE OR CHANGES IN MY TEST MENU, WHO SHOULD I CONTACT?

You should contact the State Agency where your laboratory is located. You can find this information as well as other information about CLIA at www.cms.hhs.gov/clia or you may contact the CMS CLIA Central Office at 410-786-3531.

WHERE CAN I FIND ADDITIONAL INFORMATION AND GUIDANCE?

Refer to the "The State Operations Manual", Appendix C – Interpretive Guidelines (CMS Publication 7) available on the CMS website at: www.cms.hhs.gov/clia.

Links to other laboratory-related resources can be found at these websites:

CDC: www.phppo.cdc.gov/clia/default.asp
FDA: www.fda.gov/cdrh/CLIA/index.html

NOTE: This brochure is not a legal document. The official CLIA program provisions are contained in the relevant law, regulations and rulings.

Brochure #5
March 2006

Section: clinical Services	
POLICY AND PROCEDURE: Pharmaceutical Services	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:_____

POLICY:

The site will maintain competent, efficient and ethical Pharmaceutical Services According to state and federal statues for the health and safety of its patients.

PROCEDURE:

A. Drugs and medication supplies are maintained secure to prevent unauthorized access.

1. All drugs (including sample and over-the-counter), medication supplies, prescription pads and hazardous substances are securely stored in a lockable space (room, closet, cabinet, drawer) within the office/clinic (CA B&P Code, 4051.3). Keys to the locked storage area are available only to staff authorized by the physician to have access (16 CCR, Chapter 2, Division 3, Section 1356.32).

**During business hours, the lockable space may remain unlocked ONLY if there is no access to this area by unauthorized persons and authorized clinic personnel remain in the immediate area at all times. At all other times, all drugs (including sample and over-the-counter), medication supplies, prescription pads and hazardous substances must be securely locked.

2. Controlled drugs are stored separately from other drugs, in a secured, lockable space accessible ONLY to authorized personnel (including physicians, dentists, podiatrists, physician assistants, licensed nurses and pharmacists) (Control Substances Act, CFR 1301.75). There is no need for the controlled substances to be double locked.

**Controlled substances include all Schedules I, II, Ill, IV and V substances listed in the CA Health and Safety Code, Sections 11053-11058.

3. A dose-by-dose controlled substance distribution log is maintained, including:
   A. Date
   B. Provider's DEA number
   C. Name of controlled substance
   D. Original quantity of controlled substance
   E. Dose administered, Number of remaining doses
   F. Name of patient receiving controlled substance
   G. Name of authorized person dispensing controlled substance

B. Drugs are handled safely and stores appropriately.

1. Preparation

- Drugs are prepared in a clean area, or "designated clean" area if prepared in a multipurpose room.
- Drugs or medication supplies are considered "adulterated" if it contains any filthy, putrid or decomposed substance, or if it has been prepared, packed or held under unsanitary conditions (21 USC, Section 351).

2. Storage:
   - Items other than medications in refrigerator/freezer are kept in a secured, separate compartment from drugs, as these items may potentially cause contamination.
   - Drugs are stored separately from test reagents, germicides, disinfectants and other household substances.
   - Drugs for external use are stored separately from drugs for internal use.
   - Drugs are stored under appropriate conditions of temperature, humidity and light, so that the identity, strength, quality and purity of the drug product are not affected (21 CFR, Section 211.142). Room temperature where drugs are stored does not exceed 30°C (86°F) (Title22, Section 75037(d)).

3. Immunobiologics:
   - Vaccines are placed in a refrigerator or freezer (not on the door) immediately upon receipt on site and are stored according to specific instructions in the package insert for each vaccine.
   - Vaccines, such as DTP, DtaP, DT, Td, Hep A, Hep B, Enhanced Inactive Polio (E-IPV), and Pneumococcal, are kept in a refrigerator maintained at 2°- 8°C, or 35°- 46°F (at time of visit). [MMR and varicella are protected from light at all times, and kept cold]. Oral polio vaccine (OPV), MMR, MMRV and varicella vaccines are stored in a freezer maintained at -15°C, or 5°F, or lower (at time of visit). Failure to adhere to recommended specifications for storage and handling immunobiologics could make these products impotent.
   - Refrigerator and freezer temperatures must be checked at least once a day and documented (U.S. Pharmacopeia! Convention Regulations and Recommendations). However, the CA DHCS Immunization Branch recommends checking temperatures twice a day, first thing in the morning and last thing at night. (See Attachments)
   - The most current Vaccine Information Statements (VIS) are available from state and local health departments or can be downloaded from the CDC website at http://www.cdc.gov/vaccines/pubs/vis/default.htm or by calling the CDC Immunization Hotline at **800-232-2522**.

4. Hazardous substances (Substances that are physical or health hazards):
   - Safety practices on site are followed in accordance with current/updated CAL-OSHA standards.

- The manufacturer's label is not removed from a container as long as the hazardous material (or residues from the material) remains in the container.
- All portable containers of hazardous chemicals and secondary containers (into which hazardous substances are transferred or prepared) require labeling. Hazardous substances are appropriately labeled with the following information:
  a. Identity of hazardous substance
  b. Description of hazard warning: can be words, pictures, symbol
  c. Date of preparation or transfer
  ****Exception:** Labeling is NOT required for portable containers into which hazardous chemicals are transferred from labeled containers, and which are intended only for the immediate use of the individual who performs the transfer.**
- Site has method(s) in place for drug and hazardous substance disposal. Proper disposal is via the site's contracted/licensed medical waste hauler.

C. Drugs are dispensed according to State and Federal drug distribution laws and regulations.

1. Drug Expiration:
   - There are no expired drugs on site, as they may not be distributed or dispensed.
   - The manufacturer's expiration date must appear on the label of all drugs. All prescription drugs not bearing the expiration date are deemed to have expired.
   - If a drug is reconstituted at the time of dispensing, its label must contain expiration information for both the reconstituted and unconstituted drug.
   - Site has a procedure to check expiration date of all drugs (including vaccines and samples), and infant and therapeutic formulas. Must be done AT LEAST monthly. A log is preferred, but it is acceptable to clearly mark the outside of the drug packages with the expiration date.
2. Prescription Labeling
   - All stored and dispensed prescription drugs are appropriately labeled with:
     a. Provider's name
     b. Patient's name
     c. Drug Name
     d. Dose
     e. Frequency
     f. Route
     g. Quantity dispensed
     h. Manufacturer's name and lot number
3. Drug Dispensing and Administration

- Each prescription medication is dispensed in a container that is not cracked, soiled or without secure closures (Title 22, CCR, Section 75037 (a).
- Drug dispensing is in compliance with all applicable State and Federal laws and regulations. Drugs are not offered for sale, charged or billed to Medi-Cal members (Business and Professions Code, Article 13, Section 4193).
- Drugs are dispensed ONLY by a physician; pharmacist or other persons (i.e. NP, CNM, RN,PA) lawfully authorized to dispense medications upon the order of a licensed physician or surgeon. Personnel, such as medical assistants, office managers, and receptionists DO NOT DISPENSE DRUGS.
- California Pharmacy Law *does not* prohibit furnishing a limited quantity of sample drugs if dispensed to the patient in the package provided by the manufacturer, no charge is made to the patient, and appropriate documentation is made in the patient's medical record (CA Business and Professions Code, Sections 4170, 4171).
- Administration of medications ordered by the licensed practitioner may be completed by the MA using the following procedures:
    - Prepare Medication in a clean area
    - Have the ordering practitioner or another licensed practitioner (i.e. MD, NP, PA, CNM, RN, LVN) verify the medication and dosage prior to administration of the drug.
        - Showing the checking practitioner the bottle or vial and medicine cup or syringe,
        - If the practitioner checking the medication is not the practitioner that ordered the drug show the checking practitioner the patient's chart with the original order.
        - Administer to the patient only after a licensed practitioner has checked the prepared medication.

    Note: No MA may administer any anesthetic agent or any medication mixed with an anesthetic agent (e.g. Rocephin diluted with Xylocaine).

4. Vaccine Information Statements (VIS)
    - Since 1994, the National Childhood Vaccine Injury Act, Section 2126 of the Public Health Service Act, mandates that parents/guardians or Adult patients be informed before vaccines are administered. Health care providers must give a copy of the most recent VIS to patients prior to each vaccination dose of DTaP, Td, MMR, IPV, Hep B, Hib, Varicella and Pneumococcal Conjugate. VIS for other vaccines are available through the CDC website referred to previously.
    - VIS for distribution to patients are present on site. Site personnel should be able to verbalize standard practices regarding VIS distribution.

5. Pharmacy:
   - If there is a pharmacy on site, it is licensed by the CA State Board of Pharmacy, with a licensed pharmacist monitoring drug distribution and current policies/procedures for drug storage and dispensing.

*****Note: All site review survey deficiencies related to Pharmaceutical Services REQUIRE a corrective action plan.** ***

Attachments: Temperature Log for Vaccines (Fahrenheit)
Temperature Log for Vaccines (Celsius) Vaccine
Storage Troubleshooting Record

Vaccine Disaster Recovery Plan

Practice Name:	**County:**
Person Completing Form:	**Date:**

If you have any questions about vaccine transportation or stability call: 1-877-243-8832 (CA Vaccines for Children Program)

In advance of emergency, all providers should:

1. Identify an alternative storage facility (e.g., hospital, health department, fire department, etc.) with backup power (generator) where the vaccine can be properly stored and monitored for the interim.
2. Ensure the availability of staff to pack and move the vaccine.
3. Maintain the appropriate packing materials (coolers, gel packs, dry ice for Varicella, etc.)
4. Ensure a means of transport for the vaccine to the secure storage facility.

NOTE: Whenever possible, facilities should suspend vaccine activities BEFORE the onset of emergency conditions to allow sufficient time for packing and transporting vaccine.

Emergency Procedures

A. List emergency phone numbers, companies and points of contact for:

Designated person(s) responsible for:

- **O** Monitoring the operation of the vaccine storage equipment and systems daily.
- **O** Track inclement weather conditions. Set up and maintain a monitoring/notification system during times of inclement weather or other conditions that would create a shutdown in power. An alarm/notification system is recommended for practices with an inventory of $5000 or more.
- **O** Assure the appropriate handling of the vaccine during the disaster or power outage.

Name of Employee	Title of Employee	Work Phone	Home Phone
Primary			
Backup			

Determine if your refrigerator is having a mechanical failure (no lights in the refrigerator, no fan noise, etc) or if the building has lost electrical power. Check with the building maintenance to ensure that the generator is operational and has been activated. If a timeframe for the restoration cannot be determined, implement the following procedures.

Designated Company responsible for restoring electrical power to location in the event of a power failure.

Electrical Power Company	Point Of Contact	Work Phone	Emergency Phone

Building Maintenance	Point Of Contact	Work Phone	Emergency Phone

Designated Company responsible for Repair where the compressor or other refrigerator equipment has been destroyed or you need emergency maintenance.

Name of repair company	Point of contact	Phone Number

Designated Company responsible for: Supplying Dry Ice for Varicella/MMR packing, when a location with a backup generator cannot be identified within a reasonable distance. Preparations should be made to have coolers, frozen ice packs and/ or dry ice to temporarily and safely store your Varicella/MMR vaccine.

Name of Dry Ice Company	Point Of Contact	Telephone Number

B. List Back-up locations, phone numbers and points of contacts for:

- A location with a backup generator. This may be the local hospital, retirement home, fire station, another practice or an employees' home. Make arrangements with the site to store your vaccine there when inclement weather predictions call for such inclement weather and when your vaccine storage equipment cannot be fixed or the power cannot be restored within 6 hours. Before moving your Vaccine, call the location to ensure their back-up generator is working

Alternate Facility	Point of Contact	Work Phone	Emergency Phone

C. **Entering Vaccine Storage Facility:**

Describe how to enter the building and vaccine storage spaces in an emergency if closed or after hours. Include a floor diagram and the locations of:

Item	**Location**
Doors	
Flash lights	
Spare Batteries	
Light Switches	
Keys	
Locks	
Alarms	
Circuit Breakers	
Packing Materials	

D. Conduct an inventory before you transport the vaccine.

E. Package the vaccine in a well insulated container with ice packs.

Unpackaged vials of DtaP, eiPV, Hib, Hep A,Hep *AlB*, Influenza, PCV7, PPV23, etc, must not directly touch cold packs as the vaccine may be inactivated. It is best to keep vaccines in their original package during transport. MMR is the exception and may be

Transported directly on cold packs. Remember that Varicella must be kept frozen therefore package Varicella separately from the other vaccines. Do not expose the other vaccines (except MMR) to freezing temperatures.

F. Move vaccines to back up storage according to pre-arranged plans.

- How to load transportation vehicle
- Routes to take (alternative routes if necessary)
- Time in route

D Ensure vaccine containers are properly in the emergency storage facility. (Varicella and MMR in the freezer; refrigerated vaccines in refrigerator, adequate circulation; functioning temperature monitoring devices, etc)

G. Preparation:

Fill the empty space in your refrigerator with jugs of water and line the sides and bottom of your freezer with ice packs. In the event that your refrigerator/freezer is out of order, this practice will help maintain the temperature for a longer period of time.

Other useful information:

Immunization Branch California Department of Health Services	www.dhs.ca.gov	2151 Berkeley Way Room 712 Berkeley, CA 94704	1-877-243-8832
National Weather Service	www.nws.noaa.gov/		
Vaccine Manufacturers	Merck Sharpe & Dhome		1-800-672-6372
	Aventis Pasteur		1-800-822-2463
	GlaxoSmith Kline		1-888-825-5249
	Wyeth Lederle Labs		1-800-666-7248

Controlled Substance Log

Medication Name: _____ Dosage: _____

Original Quantity of Drug: _____ Lot Number: _____

Manufacturer Name: _____

Physicians DEA Number: _____ DEA Expires: _____

Date Administered	Name of Patient Receiving Drug	Quantity Dispensed/ Additions	Route IM/IV	Remaining Doses on Hand	Print Name of Authorized Person dispensing drug	Initials

Section: Clinical Services	
POLICY AND PROCEDURE: Radiology Services	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:_____

POLICY:

The site will meet California DHCS Radiological inspection and safety regulations by ensuring that radiation is used safely and effectively, individuals are protected from unnecessary radiation exposure and that environmental quality is preserved and maintained (17 CCR §30255, §30305, §30404, §30405).

PROCEDURE:

A Site has current CA Radiologic Health Branch Inspection Report, if there is radiological equipment on site.

1. If no current inspection report on site, there is either a:

- Short Form Sign-off Sheet (issued for minimal problems that are easily corrected) or
- Notice of Violation Form (issued if there are more serious violations) with an approval letter for a corrective action plan form the CA Radiologic Health Branch.

2. Equipment inspection, based on a "priority" rating system, is established by legislation (CA H&S Code, Section 115115).

- Mammography equipment is inspected annually (Mammography Quality Standards Act, 21 CFR, Section 900), and must have federal FDA Certification on site *and* CA Mammography X-ray Equipment and Facility Accreditation Certification posted on the machine.
- High Priority equipment (e.g. fluoroscopy, portable X-ray) is inspected every three years.
- Medium Priority equipment is inspected every 4-5 years depending on the volume of patients, frequency of x-ray equipment use, and likelihood of radiation exposure.
- DEXA scanner equipment: According to the CA Radiological Branch, a lead apron/shield and gonad shields are usually not required. The CA Radiologic Health Branch (RHB) has additional requirements. Such as, the registration of the

Dexa Scanner and use of dosimeter badges. Ref: CCR Title 17 Sections 3011,30305,3040

- If reviewer is uncertain about the "current" status of equipment inspection, call the Radiological Health Branch.

B. The following documents are <u>posted</u> on site:

1. Current copy of Title 17 with a posted notice about availability of Title 17 and its location.
2. "Radiation Safety Operating Procedures" posted in a highly visible location.
3. "Notice to Employees Poster" posted in highly visible location.
4. "Caution, X-Ray" sign posted on or next to door of each room that has X-Ray equipment.
5. Physician Supervisor/Operator certificate posted and within current expiration date.
6. Technologist certificate posted and within current expiration date.
   - If there are a large number of technicians, a list of names, license numbers and expiration dates may be substituted.
   - The Certified Radiological Technologist (CRT) certificate permits the technologist to perform all radiology films except mammography and fluoroscopy, which require separate certificates.
   - The "Limited Permit" limits the technician to one of the 10 X-ray categories specified on the limited certificate: Chest, Dental Laboratory, Dermatology, Extremities, Gastrointestinal, Genitourinary, Leg-podiatric, Skull, Torso-skeletal, and X-Ray bone densitometry.

C. The following radiological protective equipment is present on site:

1. Operator protection devices: radiologic equipment operator must use lead apron or lead shield.
2. Gonadal shield (0.5 mm or greater lead equivalent): for patient procedures in which gonads are in direct beam.

****Notes:**

- The Radiologic Health Branch of the Food, Drug, and Radiation Safety Division of the CA Department of Health Care Services enforces the Radiation Control Laws and Regulations designed to protect both the public and employees against

Radiation hazards. Enforcement is carried out through licensing, registration and periodic inspection of sources of radiation, such as radiation machines.

- For questions regarding radiologic safety (e.g. expired or no inspection letters on site), call CA DHCS Radiologic Health Branch (Compliance Unit) General Information (daytime hours) at (916) 327-5106.

Posting Required by Title 17 §30255(b) (2)

RADIATION SAFETY INSTRUCTIONS

In accordance with the "California Code of Regulations'', Title 17, the registrant supervisor is responsible for radiation safety. Responsibilities include: 1) assuring that only component persons operate x-ray equipment under his/her jurisdiction; 2) the supervisor must provide safety rules to each individual operating x-ray equipment and installation meet the applicable requirements of the regulations.

A. Items pertinent to radiation safety include:

1. Careful collimation is used to restrict the X-ray beam to the area of clinical interest only. (The X-ray field may never be larger than the size of the film used.)
2. Gonadal shielding is used where and when appropriate. Policies regarding the use of gonadal shielding must be made available to X-ray technical personnel.
3. The X-ray room is cleared of all nonessential persons before X-ray technical personnel take X-rays.
4. X-ray technical personnel stand behind a leaded shield or in a protective booth for every X-ray exposure.
5. Personnel monitoring devices must be worn when they are provided or required. The monitoring device must be worn on the collar of the apron when a lead apron is worn.
6. X-ray technical personnel do not hold patients and no person is regularly or repeatedly used to hold patients. (Exception: in real emergencies when there is no other method of obtaining diagnostic radiographs, X-ray technical personnel may hold a patient.)
7. Individuals who hold patients use appropriate protective apparel such as a leaded apron (at least 0.25 millimeters of lead equivalence) and lead gloves or lead shields.

B. Items pertinent to technical aspects of X-ray examinations:

1. Use the best film-screen combination for the lowest dose practicable and commensurate with objectives of the X-ray examination.
2. Know exactly what examination and which view or views are to be taken.
3. Position the patient correctly for the required examination and view before making the actual exposure.
4. Use high (optimum) kilovolt peak (kVp) and low milliampere-second (mAs) techniques for low dose radiography consistent with obtaining a diagnostic quality image.
5. Take steps to avoid patient motion by clearly instructing patients not to move, by using appropriate immobilization or positioning aids, and by keeping the patient comfortable and under constant observation.
6. Use unexposed film that has not passed its expiration date.
7. Handle films carefully to prevent artifacts due to static electricity, fingerprints, crinkle marks, and other causes.
8. Ensure that the cassette closure provides good film screen contact.
9. Keep the dark room "light-tight" by sealing off light leaks.
10. Use only fresh (not exhausted) chemicals for film processing.
11. Make sure the processing temperature is correct for the chemicals and film used.
12. Keep cassettes and screens clean.
13. Assure the film processor is cleaned regularly.
14. Place positioning markers correctly on the film and identify each film with the patient's name.
15. Ensure no sight development is done if films are hand developed.

NOTE: FAILURE TO OBTAIN DIAGNOSTIC QUALITY RADIOGRAPHS WITH THE LEAST EXPOSURE TO THE PATIENT, FOR THE X-RAY EXAMINATION REQUIRED, MEANS FAILURE TO MEET THE ACCEPTED STANDARD OF CARE.

Notices Provided by: Quality Assurance Services, Inc. Medical Physicists (888) 727-2550

PCP	Page 1 of 3
Section: Preventive Services	
POLICY AND PROCEDURE: Preventive Services Screening and Equipment	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____

POLICY:

Preventive health care services and health appraisal examinations are provided on a periodic basis for detection of asymptomatic diseases. Examination equipment, appropriate for primary care services is required to be available at the Primary Care Physician office site.

PROCEDURE:

The following equipment shall be maintained onsite and will be appropriate to the population served.

A. Examination table: the examination table has a protective barrier to cover the exam table surface that is changed between patient contact. The exam table is in "good repair". "Good repair" means clean and well maintained in proper working order.

B. Scales: Precise, reproducible measurements required correct equipment, which is maintained and regularly checked (per manufacturer recommendations or at least annually), for proper functioning and accuracy.

- **Infant scales** are marked and accurate to increments of one (1) ounce or less, and have a capacity of at least 35 pounds. Infant and children are weighed undressed or wearing minimal indoor clothing. If the child resists to the extent that he/she cannot be weighed accurately, document in the medical record that the child resisted and the weight measurement is imprecise.

- **Standing floor scales** are marked and have accurate to increments of one-fourth (1/4) pound or less with a capacity of at least 300 pounds.

- **Balance beam or electronic scales** are appropriate for clinic use.

- **Electronic or digital scales** have automatic zeroing and lock-in weight features.

- **Spring balance scales (e.g. bathroom scales) are UNSATISFACTORY** for clinical use.

C. Measuring stature devices: includes length, height and head circumference

- Rigid 90° right angle headboard block that is perpendicular to the recumbent measurement surface or vertical to the wall mounted standing measurement surface.
- Flat, paper or plastic non-stretchable tape or yardstick marked to one-eighth inch (1/8 in or 1 mm) or less. The "0" of the tape is exactly at the base of the headboard for recumbent measurement, or exactly at foot level for standing measurement.
- Non-flexible footboard at 90° right angle perpendicular to the recumbent measurement surface or a flat floor surfaces for standing. Adult scale height measuring devices are unacceptable.
- Head circumference measurement uses a non-stretchable tape measuring device marked to (1/8 in. or 1 mm) or less (up to 24 months of age).

D. Basic exam equipment available for use in exam rooms:

- Thermometers: oral and/or tympanic
- Stethoscope and sphygmomanometer with various sized cuffs (e.g., child, adult, obese/thigh)
- Percussion hammer
- Tongue blades
- Patient gowns are appropriate to the population served on site.
- Ophthalmoscope
- Otoscope with adult and pediatric ear speculums

E. Vision testing:

- Eye charts: both literate (e.g. Snellen) and illiterate (e.g. "E" chart, "kindergarten" chart, Allen Picture Card Test) eye charts are available.
- Heel lines are aligned with the center of the eye chart at a distance of 10 or 20 feet depending on whether the chart is for 10 foot or 20 foot distance. Eye charts are located in an area with adequate lighting and at height appropriate to patient (adjustable).

- **Eye "occluders"** that are disposable (e.g. Dixie cups or tongue blades with back-to-back stickers) are acceptable. Non-disposable occluders are disinfected between patients.

F. Audiometric testing:

- **Tester will assess the testing room for noise level** prior to the start of testing. To ensure the testing room is quiet enough to perform the hearing screening.

PCP	Page 1 of 1
Section: Preventive Services	
POLICY AND PROCEDURE: Health Education	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:_____

POLICY:
Health education services and Plan-specific resource information are available to Plan members.

PROCEDURE:

A. Health education materials will be maintained on site or made available upon request.

1. Providers and/or staff will provide health education materials and/or resources to members as appropriate.

2. Providers and/or staff providing verbal health education, educational materials, Plan-specific resources and/or referrals to classes will document titles/content in the patient's medical record.

B. Educational materials maintained on site will be applicable to the practice and the population served.

C. Educational materials will be available in threshold languages identified for county and/or area of site location.

Materials to Keep You Informed

Health education brochures provide you with information on how to stay healthy and/or manage a disease. You can call our **Health Education department at 1-323-827-6036** or email: BlueShieldofCAHealthEducation@blueshieldca.com . We also have materials available in other topics, languages and in alternative formats. Please call the Health Education Department for more information or go to our web **site** https://www.blueshieldca.com/promise/providers/index.asp?secProviders=health-education-materials

CLAS DEPARTMENT

Materials Order form

Please allow 30 days for delivery of your order. You can request up to 5 copies of the items selected. All Health Education materials can be available in member's preferred language and/or in alternative formats (i.e. Braille, Large Print & Audio) upon request.

Request Submitted By: _____

Provider Name: _____

Specialty: _____

Address: _____

City: _____ **Zip Code:** _____

Phone #: _____

Email: _____

Please complete the order form and fax to

Blue Shield Promise
Health Plan
CLAS Department
601 Potrero Grande Dr.
Monterey Park, CA
91755 Fax: (323)
889-5407

Languages: (E)nglish, (S)panish, (V)ietnamese, (C)hinese, (Kh)mer, (Am)Armenian, (R)ussian, (T)agalog, (K)orean, (F)arsi, (Ab)Arabic, (H)mong

Please circle your choice of language(s) for each material that you're requesting.

Languages: (E)nglish, (S)panish, (V)ietnamese, (C)hinese, (Kh)mer, (Am)Armenian, (R)ussian, (T)agalog, (K)orean, (F)arsi, (Ab)Arabic, (H)mong

MATERIAL TITLE	Source	Format	E	S	C	Kh	Am	R	T	K	F	Ab	H
Tools & Resources													
Office Hours Sheet: Chart contains days of the week in all threshold languages.	LA Care	Template	E	S	C	Kh	Am	R	T	K	F	-	-
Request or Refusal of Interpreting Services Form: To be completed by the patient, and included in the patient's medical chart.	Blue Shield Promise	Form	E	S	C	Kh	Am	R	T	K	F	Ab	H
CLAS (Cultural & Linguistic Appropriate Services) Referral Form: This form can be used to refer members to a community based organization. Please see CLAS Community Resource Directory for a list of organization & agencies.	Blue Shield Promise	Form	E	-	-	-	-	-	-	-	-	-	-
C&L Materials Matrix	Blue Shield Promise	Template	E	-	-	-	-	-	-	-	-	-	-
Document Insert (for Medi-Cal Members)	Blue Shield Promise	Template	E	S	C	Kh	Am	R	T	K	F	Ab	
Notice of Translation (for Commercial Members)	Blue Shield Promise	Template	E	S	C	-	-	-	-	K	-	-	-
Notice of Translation (for Healthy Families Members)	Blue Shield Promise	Template	E	S	-	-	-	-	-	-	-	-	-
Summary of Provider Responsibility in provision of Cultural & Linguistic Appropriate Services	Blue Shield Promise	Template	E	-	-	-	-	-	-	-	-	-	-
Language Assistance Program Policy	ICE	Template	E	-	-	-	-	-	-	-	-	-	-
Preferred Language Label: Labels that allow providers/staff to document the patients preferred language in medical chart.	LA Care	Template	E	-	-	-	-	-	-	-	-	-	-
Request/Refusal Label: Labels that allow providers/staff to document the patients request/refusal for interpreter services in medical chart.	LA Care	Template	E	-	-	-	-	-	-	-	-	-	-
Grievances Forms: If your patients are unhappy with anything about their care or with Blue Shield Promise Health Plan, we want to know about it. To be fill out by the patient, and included in the patient's medical chart.	Blue Shield Promise	Form	E	S	C	Kh	Am	R	T	K	F	Ab	-
Pharmacy Ancillary Labels: Allows pharmacists to instruct patients how to use and/or provide information about the medication they are receiving, in ten languages.	LA Care	FACT SHEET	E	S	C	Kh	Am	R	T	K	F	-	-
Provider & Staff Language Capability: ICE Self-Assessment Tool	ICE/All Health Plans	FORM	E	-	-	-	-	-	-	-	-	-	-
Tools & Resources													
Protocol for How to Access Interpreting Services	Blue Shield Promise	FACT SHEET	E	-	-	-	-	-	-	-	-	-	-

MATERIAL TITLE	Source	Format	E	S	C	Kh	Am	R	T	K	F	Ab	H
After-Hours Interpreting Services Survey - It will help us understand if your office needs help in providing after hours interpreter services.	Blue Shield Promise	Survey	E	-	-	-	-	-	-	-	-	-	-
CLAS Community Resource Directory: Directory provides a list of organizations that are available to assist PPGs and providers in ensuring quality medical care to diverse patient populations. Providers & staff can refer members directly or by submitting a CLAS referral request form to Blue Shield of CA Promise.	Blue Shield Promise	Directory	E	-	-	-	-	-	-	-	-	-	-
Interpreting Service Poster - Physicians' office & Pharmacies: Patients' Rights to receive Interpreting Services (Copies can be ordered through L.A. Care's on-line materials order form).	LA Care	Poster	E	S	C	Kh	Am	R	T	K	F	-	-
Telecommunications Relay Services: Program Access bulleting from the state which describes services for the hearing impaired & how to access them.	State	FACT SHEET	E	-	-	-	-	-	-	-	-	-	-
California Access Program: Information on how to order communications devices at "NO COST" to those qualified members who are disabled.	State	Brochure	E	S	C	-	Am	R	T	K	-	-	H
Health Education Materials for the Member in various languages: Please contact Health Education Department for further information.	Blue Shield Promise Health Education Department	Order Form	E	-	-	-	-	-	-	-	-	-	-
Language Identification Card (a guide to the 27 most requested foreign languages)	Pacific Interpreters	Info Card	E	S	C	Kh	Am	R	T	K	F	Ab	-
Language Interpreting Services Sign	Pacific Interpreters	Poster	E	S	C	Kh	Am	R	T	K	F	Ab	-
Language ID Poster: Various sized materials that state "Point to your language and an interpreter will be provided to you at no cost" in the most frequently requested languages and dialects nationwide. (*Please circle the format you would like to receive*)	Pacific Interpreters	Mini Poster Easel Large Poster ID Brochure	E	S	C	Kh	Am	R	T	K	F	Ab	-
Quick Reference Card (4"X6"): This handy card lists the service access information for quick reference.	Pacific Interpreters	Info Card	E	-	-	-	-	-	-	-	-	-	-
Quick Reference Badge (3.5"X2"): A durable plastic card for quick reference of your service access information. Available in horizontal and vertical formats, it can be easily added to any ID badge.	Pacific Interpreters	Badge	E	-	-	-	-	-	-	-	-	-	-
Labels (2.5"X1"): Please these labels on phones, ID badges, or patient folders for quick reference of your service access information.	Pacific Interpreters	Label	E	-	-	-	-	-	-	-	-	-	-
How to Sheet (8.5"X11"): Provides step-by-step instructions on how to use our telephone interpreting service in three different scenarios.	Pacific Interpreters	FACT SHEET	E	-	-	-	-	-	-	-	-	-	-
I Speak Cards (3.5"X2"): Distribute this card to returning patients for quick language and name identification.	Pacific Interpreters	Card	E	-	-	-	-	-	-	-	-	-	-

Languages: (E)nglish, (S)panish, (V)ietnamese, (C)hinese, (Kh)mer, (Am)Armenian, (R)ussian, (T)agalog, (K)orean, (F)arsi, (Ab)Arabic, (H)mong

MATERIAL TITLE	Source	Format	E	S	C	Kh	Am	R	T	K	F	Ab	H
ASK ME 3: Brochure for patients. Designed to help communication between patients and providers.	Pfizer	Brochure	E	S	-	-	-	-	-	-	-	-	-
Cultural Diversity Matrix: Include information on various ethnic background, and health practice	Blue Shield Promise	FACT SHEET	E	-	-	-	-	-	-	-	-	-	-
CLAS Provider & Staff ToolKit : CLAS Resources, Tools, Forms and Training Opportunities	Blue Shield Promise	Tool Kit	E	-	-	-	-	-	-	-	-	-	-
10 Commandments of Communicating With People with Disabilities	Health & Human Resources Agency-SD	FACT SHEET	E										
Disability Language & Etiquette	Health & Human Resources Agency-SD	FACT SHEET	E										
Better Communication Better Care: Provider Tools to Care for Diverse Populations	ICE	Booklet	E	-	-	-	-	-	-	-	-	-	-
Education & Trainings													
Health Care Interpreting Training Programs: Information on various training opportunities of Medical Interpreting Services	LA Care	FACT SHEET	E	-	-	-	-	-	-	-	-	-	-
Do You know? Informational brochure for provides & staff on cultural competence and the "Ask Me 3" program.	Pfizer	Brochure	E	S	-	-	-	-	-	-	-	-	-
Provider Office Site Training request Form (Staff & Providers): Educational program offered by Blue Shield Promise CLAS Department in efforts to help direct contracted clinics about CLAS requirements, services, and available resources.	Blue Shield Promise	On-Site Training	E	-	-	-	-	-	-	-	-	-	-

Languages: (E)nglish, (S)panish, (V)ietnamese, (C)hinese, (Kh)mer, (Am)Armenian, (R)ussian, (T)agalog, (K)orean, (F)arsi, (Ab)Arabic, (H)mong

Section : Infection Control	
POLICY AND PROCEDURES: Blood borne Pathogens and Waste Management	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:_____

POLICY:

The site will follow the OSHA Blood borne Pathogens Standard and California Waste Management Act according to 8 CCR §5193 (Cal OSHA Health Care Worker Needle stick Prevention Act, 1999); H&S Code, §117600-118360 (CA Medical Waste Management Act, 1997); 29 CFR §1910.1030.

PROCEDURE:

I. BLOOD AND OTHER POTENTIALLY INFECTIOUS MATERIALS (OPIM)

A. OPIM are all human body fluids, any unfixed tissue or organ (other than intact skin) from a human (living or dead), and HIV or HBV-containing blood, cells, tissue, organs, cultures, medium or solutions. Containers for blood and OPIM are closable, leak proof, and labeled and/or color-coded. Double bagging is required only if leakage is possible.

II. PERSONAL PROTECTIVE EQUIPMENT (PPE)

A. PPE is specialized clothing and/or equipment for protection against bloodborne pathogen hazards, and does not include general work clothes (e.g., uniforms, cloth lab coats) that permit liquid to soak through.

B. PPE is available for staff use on site, and includes:
*Staff must know how to locate this

1. Water repelling gloves
2. Clothing barrier (e.g., gown, sheets)
3. face/eye protection (e.g., goggles, face shield)
4. Respiratory infection protection (e.g., mask)

C. Other necessary PPE are available specific to the practice and types of procedures performed on site. General work clothes are appropriate only if blood/OPIM does not penetrate through employee's work clothes, undergarments, skin, eyes, mouth, or other mucous membranes under NORMAL conditions of use.

Ill. LABELS

A. A warning label is affixed to red bagged regulated wastes, sharps containers, refrigerators/freezers containing blood or OPIM, containers used to store or transport blood or OPIM, and contaminated laundry or equipment for storage or transporting. The international "BIOHAZARDOUS WASTE" label, (fluorescent orange or red-orange with contrasting lettering/symbols) is an integral part of the container or affixed to container. Sharps containers are labeled with the words "Sharps Waste" or with the international biohazard symbol and the word "BIOHAZARD". Individual containers of blood or OPIM are exempted from warning labels if placed inside a labeled secondary container for storage, transport, or disposal. Alternative marking or color coding may be used to label contaminated laundry or specimen containers if the alternative marking permits employees on site to recognize that container requires compliance with Universal Precautions. If the contaminated laundry or specimen leaves the site, an international "Biohazardous Waste" warning label and/or red color-coding is used.

IV. NEEDLESTICK SAFETY

A. Contaminated sharps are discarded immediately. Sharps containers are located close to the immediate area where sharps are used, and are inaccessible to unauthorized persons. Sharps are not bent, removed from a syringe, or recapped. Needleless systems, sharps with engineered sharps injury protection (ESIP), and non-needle sharps are used unless exemptions have been approved by Gal/OSHA (8CCR, Section 5193). Security of portable containers in patient care areas is maintained at all times. Any device capable of cutting or piercing (e.g. syringes, hypodermic needles, needleless devices, blades, broken glass, slides, vials) are placed in a closable, puncture-resistant, labeled, leak-proof container. If these requirements are met, containers made of various materials (e.g., cardboard, plastic) are acceptable. Containers are not overfilled past manufacturer's designated fill line, or more than ¾ full. Supply of containers on hand is adequate to ensure routine change-out when filled.

V. SHARPS INJURY DOCUMENTATION

A. Site has a method in place to document sharps injuries. Date, time, description of exposure incident, sharp type/brand, follow-up care is documented within 14 days of injury incident (see attached Sharps Injury Report form).* Staff must know where to locate forms to document sharps injury

VI. CONTAMINATED LAUNDRY

A. Site has a laundry service contract or a washer and dryer on site to launder contaminated laundry (soiled with blood/OPIM or containing contaminated

Sharps). Manufacturer's guidelines are followed to decontaminate and launder reusable protective clothing. Laundry requirements are "not applicable" if only disposable PPE is used on site.

VII. REGULATED WASTE STORAGE

A. Regulated waste is contained separately from other wastes (e.g., contaminated wastes) at the point of origin in the producing facility, placed in red biohazardous bags with Biohazard label, and stored in a closed container that is not accessible to unauthorized persons. If stored outside of the office, a lock secures the entry door, gate or receptacle lid, and posted warning sign(s) in English and Spanish are visible for a distance of 25-feet. The sign wording states "CAUTION-BIOHAZARDOUS WASTE STORAGE AREA UNAUTHORIZED PERSONS KEEP OUT" or "CUIDADO-ZONA DE RESIDUOS-BIOLOGICOS PELIGROSOS-PROHIBIDA LA ENTRADA A PERSONAS NO AUTHORIZADAS." Signs prior to the passage of the Medical Waste Act, Infectious Waste, are permitted for the "life" of the sign.

B. Regulated wastes include: 1) *Biohazardous wastes,* e.g., laboratory wastes, human specimens/tissue, blood/contaminated materials "known" to be infected with highly communicable diseases for humans and/or that require Isolation, and 2) *Medical wastes,* e.g., liquid/semi-liquid blood or OPIM, items caked with dry blood or OPIM and capable of releasing materials during handling, and contaminated sharps (Health and Safety Code, Chapter 6.1, CA Medical Waste Management Act).

VIII. MEDICAL WASTE DISPOSAL

A. Medical wastes are hauled to a permitted offsite medical waste treatment facility, to a transfer station, or to another registered generator for consolidation. Hauling is by a registered hazardous waste transporter or by a person with an approved limited-quantity hauling exemption granted by the CA DHCS Waste Management Division. The limited-quantity hauling exemption is valid for a period of one year and is renewed annually. When hauling medical wastes, the transporter carries the exemption form in the transporting vehicle. A medical waste tracking document is maintained that includes name of person transporting, number of waste containers, type of medical wastes, and date of transportation. Tracking document is kept a minimum of 3 years for large waste generators and 2 years for small generators.

Note: Contaminated wastes include materials soiled with blood during the course of their use but are not within the scope of regulated wastes. Contaminated waste items need not be disposed as regulated waste in labeled red bags, but can be discarded as solid waste in regular trash receptacle.

Attached: Supply Kit Information

Sharps Injury Log

CDPH Disposal kit Web sites

http://wastewise.com/products/isolyser-sms/

OBTAINABLE FROM YOUR MEDICAL SUPPLY COMPANY

Infection Control Kit
This kit contains:

- 1 pair Latex Free Gloves
- 1 Disposable Coverall
- 1 Bouffant Cap
- 2 Antiseptic Bacterial Wipes
- 1 Red Polybag w/tie
- 1 fluid Resistant Mask w/Face Shield
- 1 Biohazard Label2" x 2"
- Fits 5'6" to 5'10" 135-210 lbs

Deluxe Infection Control Kit
The Deluxe Infection Control Kit includes:

- 1 bouffant cap
- 1 pair gloves
- 1 fluid-resistant mask/eyeshield attached (Safety Shield Combo Mask)
- 1 fluid-impervious gown with full back

Bloodborne Pathogen Protection and Cleanup Kit
Ideal for compliance to OSHA Bloodborne Pathogen Standards. The cabinet is made of plastic. MSDS sheets are included as well as individual component boxes for Personal Protection and Cleanup Kit.

Personal Protection Pack contains 1 disposable hospital gown, 1 pair of booties, 2 antiseptic towelettes (non-alcohol), 1 bouffant cap, 1 pair of nitrile gloves and 1 eye and face shield/splash mask combination.

Spill Cleanup Pack contains 1 EPA registered disinfectant, 8oz pack of absorbent powder, scoop and spatula, 1 pack of paper towels, 2 biohazard bags, 2 antiseptic towelettes (non-alcohol) and 1 pair of nitrile gloves.

Sharps Injury Log

The Following information, if known or reasonably available, should be documented within 14 working days of the date on which each exposure incident was reported.

1. Date and time of the exposure incident:_____
2. Date of exposure incident report : _____ Report written by:_____
3. Type and brand of sharp involved:_____
4. Description of exposure incident:
   - Job Classification of exposed employee:_____
   - Department or work area where the incident occurred:_____
   - Procedure being performed by the exposed employee at the time of the incident:_____
     _____
   - How the incident occurred: _____
   - Body Part(s) involved:_____
   - Did the device involved have engineered sharps injury protection? Yes ____ No____
   - Was engineered sharps injury protection on the sharp involved? Yes ____ No____

If Yes	If No
A. Was the Protective mechanism activated At the time of the exposure incident? Yes No B. Did the injury occur before, during, or after the mechanism was activated?____ _____ Comments: _____ _____ _____	A. Does the injured employee believe that a Protective mechanism could have prevented the injury? Yes No

   - Does the exposed employee believe that any controls (e.g., engineering, administrative, or work practice) could have prevented the injury? Yes ___ No____
   - Employee's; Opinion:
     _____
     _____
     _____
     _____

5. Comments on the exposure incident(e.g., additional relevant favors involved):_____
   _____
   _____
   _____
6. Employee's interview summary:_____
   _____
   _____
   _____
7. Picture(s) of the sharps(s) involved (please attach if available).

MEDICAL WASTE LOG SHEET
FOR SMALL QUANTITY GENERATOR FACILITY
Per CA Health & Safety Code (HSC) § 117928 & 117945

California law allows hospitals to pick up bio-hazardous waste from associated medical buildings when they are not required to cross any city streets or public roads. Our medical building located at the following address meets this requirement:

_____
_____
_____

As a service to the physicians of this building, _____ (name of hospital/medical building) will pick up bio-hazardous and sharps waste when properly contained. It will then be transported to the hospital's common storage facility. The hospital is contracted with _____, a registered hazardous waste hauler for the proper transport, treatment and disposal of the bio-hazardous waste. The contract is kept current and on file at: _____

IMPORTANT: Completed log sheets must be kept on-site for at least TWO years.

Container Type (e.g. sharps container, red bag with biohazard waste, etc)	**Quantity**	**Name of Hospital Staff Transporter**	**Date of Removal**	**Comments**

State of California—Health and Human Services Agency
California Department of Public Health

RON CHAPMAN, MD, MPH
Director & State Health Officer

EDMUND G. BROWN JR.
Governor

MAIL-BACK SYSTEMS APPROVED BY THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

(Revised November 2013)

- EnviroMed Safety & Compliance
  www.enviromedinc.com (877) 340-2430
- GRP & Associates
  www.sharpsdisposal.com (800) 207-0976
- Republic Services
  www.republicsharps.com (855) 737-7871
- Sharps Compliance, Inc.
  www.sharpsinc.com (800) 772-5657
- Stericycle, Inc.
  www.stericycle.com/mailback-programs/sharps.html
  (800) 355-8773
- WCM (Waste & Compliance Management, Inc.)
  www.wastewise.com (866) 436-9264
- Waste Management MedWaste Tracker
  www.wmlamptracker.com/v2/product_medwaste_start.cfm
  (800) 664-1434
- XMED Disposal, Inc.
  www.xmeddisposal.com (866) 735-9709

Note: Some medical waste transporters serve as distributors of mail-back kits — consult the Program's list of medical waste transporters. Also, many medical supply companies as well as solid waste pickup services offer mail-back containers. Before purchasing, verify that the product offered is on the above list.

► For additional information on requirements for use of these mail-back systems, contact your local health or environmental health agency, or the State Department of Public Health, Medical Waste Management Program, at (916) 449-5671.

eWaste Disposal, Inc WASTE HANDLING PROCEDURES

EWD is a fully licensed hazardous and biohazardous waste transporter. We will provide you with all required documentation which you must maintain for your records. We will make all required reports to the state. All containers supplied by EWD meet regulatory requirements.

Generators are responsible for proper segregation, packaging, and labeling of waste. The following are procedures that must be followed in order for both generator and transporter to maintain compliance with all applicable regulations. Improperly packaged container or unacceptable waste may be denied or returned to the generator and there will be a fee charged for improper packaging. Please call our office if you wish to receive more detailed information on these regulations.

SHARPS WASTE

- Sharps: Any object that is potentially contaminated or may become contaminated with bloodborne pathogens which can penetrate the skin or red bag
- Includes but is not limited to needles, scalpels, slides, capillary tubes, broken glass, and dental wires
- Must be placed in a sharps container (a rigid puncture-resistant container that, when sealed, is leak resistant and cannot be reopened)
- Container must be kept upright at all times
- Containers must be closed and locked when they become ¾ full (most containers have a full mark)
- May not be transferred from one container to another
- **Sharps containers that are not closeable or have needles protruding may not be transported**
- **Sharps in a red bag without being in a sharps container will not be removed from your facility**
- Non-sharps medical waste, mercury, extracted teeth, hazardous waste, and pharmaceuticals may not go in a sharps container
- Containers should be transported in a rigid, non-porous, secondary containment (such as a 44-gallon plastic brute container) that is labeled with "BIOHAZARDOUS" with the international biohazard symbol visible from all lateral directions. PGII containers do not require secondary containment

PHARMACEUTICAL WASTE

- Pharmaceutical: Any prescription or over-the-counter human or veterinary drug
- Must be segregated from other wastes in an EXR approved rigid container that is labeled "PHARMACEUTICAL WASTE FOR INCINERATION ONLY"
- May not be put down drain or trash
- DEA scheduled drugs must be handled separately and cannot be included in typical pharmaceutical waste

RED BAG WASTE

- Defined as:
  - Any item that contains liquid or semi-liquid blood or other potentially infectious materials (OPIM)
  - Contaminated items that would release blood or OPIM if compressed
  - Items with dried blood or OPIM
  - Any human tissues
- Red plastic bags of a specified thickness that will be leak and tear resistant that is labeled with the international biohazard symbol and the word "BIOHAZARDOUS"
- Must be in rigid, non-porous, secondary containment (such as a 44-gallon plastic brute container)
- Each bag must be tied with a "goose-neck" closure done by gathering and twisting the bag and securing it with a knot or tie
- Bags must be tied prior to transportation to prevent expulsion of contents and may not be overfilled

PATHOLOGY WASTE

- Pathology: Human or animal body parts, organs, tissues and surgical specimens (any formaldehyde, formalin, or preservative must be drained off of all tissues and handled as a separate waste stream)
- Must in a red bag and in secondary containment that is labeled "PATHOLOGY WASTE FOR INCINERATION"
- Bag must be tied with "goose-neck" closure to prevent expulsion of contents prior to transportation

TRACE CHEMOTHERAPY WASTE

- Defined as: Waste contaminated through contact with, or having previously contained chemotherapeutic agents including but not limited to gloves, disposable gowns, towels, empty intravenous solution bags and attached tubing
- Must be segregated from other wastes in a rigid plastic chemotherapy waste container or in a yellow chemotherapy bag within secondary containment. All containers and bags must be labeled with "CHEMOTHERAPY WASTE FOR INCINERATION"

AMALGAM WASTE

- Scrap (dry or non-contact) amalgam and amalgam particles or empty amalgam capsules
- Contact Amalgam including: extracted teeth, sludge from chair side traps, disposable traps, pump filter canisters, and sludge from amalgam separator wastewater treatment units
- Must be placed in airtight container labeled with purple "UNIVERSAL WASTE" label that is properly filled out
- **Amalgam waste and filters may not be rinsed down the drain, thrown in the trash, or put into sharps containers or red bags.**

FIXER AND DEVELOPER WASTE

- Spent photographic solutions
- Must be in DOT approved container containing a green "EXCLUDED RECYCLABLE MATERIAL" label that is properly filled out
- Los Angeles County requires separate containers for fixer and developer

STERILIZING SOLUTIONS

- Vapo Steril or Gluteraldehyde based solutions used for instrument sterilization
- Must be in a DOT approved container labeled with a yellow "HAZARDOUS WASTE" label that is properly filled out

OTHER HAZARDOUS WASTES

- Call for containment, storage, and labeling requirements

WASTES NOT ACCEPTED

- Radioactive materials
- Complete human remains
- Untreated category A Infectious Substances
- Mercury containing devices (mercury thermometers, sphygmomanometers, lab or other medical devices)
- DEA scheduled drugs
- Acutely hazardous wastes

Accumulation Requirements

- Red bag waste under 20 pounds a month: 30 days from start of accumulation
- Red Bag waste over 20 pounds a month: 7 days from the start of accumulation
- Any red bag with an odor that is considered a nuisance must be disposed of immediately
- Sharps waste: 30 days from being closed (must be closed with ¾ mark reached)
- Pharmaceuticals, Fixer/developer, amalgam, sterilizing solutions: 365 from start of accumulation or 90 days from point container is full whichever is sooner.

OSHA REQUIREMENTS

- Use Universal Precautions (assume all blood and bodily fluid is known to be infectious for a bloodborne pathogens such as Hepatitis or HIV)
- Have exposure control plan
- Minimize employee exposure with work practice controls and use of personal protective equipment
- Contaminated materials should be disposed of immediately in appropriate containers with proper color and labeling.
- The hepatitis B vaccination series must be made available at no cost to all employees with occupational exposure within 10 days of employment
- All employees with potential occupational exposure should be trained with a minimum of explanation of the bloodborne pathogens standard, examples of proper labels and containers, description of bloodborne disease, explanation of modes of transmission, explanation of the exposure control plan, methods to reduce exposure, and procedure to follow if exposure incident occurs
- Following an exposure incident a confidential medical evaluation must be made available at no cost to the employee
- Maintain sharps injury log of any percutaneous injuries from contaminated sharps

BLOODBORNE PATHOGEN
EXPOSURE CONTROL PLAN

Adapted from the Western Kentucky University Industrial Hygiene Student Association Sample Bloodborne Pathogens Exposure Control Plan.

This sample plan is provided only as a guide to assist in complying with the OSHA Bloodborne Pathogens standard 29 CFR 1910.1030, as adopted by 803 KAR 2:320. It is not intended to supersede the requirements detailed in the standard. Employers should review the standard for particular requirements which are applicable to their situation. It should be noted that this model program does not include provisions for HIV/HBV laboratories and research facilities which are addressed in section (a) of the standard. Employers will need to add information relevant to their particular facility in order to develop an effective, comprehensive exposure control plan. Employers should note that the exposure control plan is expected to be reviewed at least on an annual basis and updated when necessary.

Facility Name: _____

Facility Address: _____

Date of Preparation: _____

Signature of Provider/Designee who prepared the plan: _____

Annual Review Date(s): ___/____ /____, ___/____ /____, ___/____ /____, ___/____ /____

1. EXPOSURE DETERMINATION

OSHA requires employers to perform an exposure determination concerning which employees may incur occupational exposure to blood or other potentially infectious materials. The exposure determination is made without regard to the use of personal protective equipment (i.e. employees are considered to be exposed even if they wear personal protective equipment). This exposure determination is required to list all job classifications – full and part time and per diem - in which all employees may be expected to incur such occupational exposure, regardless of frequency. At this facility the following employees will have occupational exposure:

[ ] Physicians
[ ] Physician Assistants
[ ] Nurses, including Nurse Practitioners
[ ] Laboratory Technicians
[ ] Medical Assistants
[ ] Other: _____

In addition, OSHA requires a listing of job classifications in which some employees may have occupational exposure. Since not all the employees in these categories would be

expected to incur exposure to blood or other potentially infectious materials, tasks or procedures that would cause these employees to have occupational exposure are also required to be listed in order to clearly understand which employees in these categories are considered to have occupational exposure.

The following employees may have occupational exposure:

[ ] Housekeeping Staff
[ ] Administrative/Clerical Staff
[ ] Receptionists
[ ] Other: _____
[ ] Other: _____

The following procedures usually performed in our office involve a potential risk of occupational exposure to blood or other potentially infectious materials:

[ ] Patient examinations
[ ] Burn treatment and dressing
[ ] Wound treatment and dressing
[ ] Cerumen Removal
[ ] Foreign body removal (eg: ear, nose, skin)
[ ] I&D abscess
[ ] Laceration Repair
[ ] Hematoma, subungal
[ ] Spinal lumbar puncture
[ ] Venopuncture
[ ] Injection (eg: antibiotic, adrenalin, etc.)
[ ] Laboratory Procedures (PKU specimen, hematocrit, sed rate, etc)
[ ] Immunizations
[ ] Changing diapers where the presence of blood is visible or suspected)
[ ] Other: _____
[ ] Other: _____
[ ] Other: _____

2. IMPLEMENTATION SCHEDULE AND METHODOLOGY

OSHA also requires that this plan also include a schedule and method of implementation for the various requirements of the standard. The following complies with this requirement:

COMPLIANCE METHODS

Universal precautions will be observed at this facility in order to prevent contact with blood or other potentially infectious material will be considered infectious regardless of the perceived status of the source individual.

Engineering and work practice controls will be utilized to eliminate or minimize exposure to employees at this facility. Where occupational exposure remains after institution of these controls, personal protective equipment shall also be utilized. At this facility the following engineering controls will be utilized:

[ ] Sharps disposal containers
[ ] Engineered sharps (self sheathing needles, sharps safety needles/syringes, etc)
[ ] Other: _____

The above controls will be examined and maintained on a regular schedule. The schedule for reviewing the effectiveness of the controls is as follows:

[ ] The effectiveness of the controls will be examined/monitored daily
[ ] The effectiveness of the controls will be examined/monitored weekly
[ ] The effectiveness of the controls will be monitored _____

The individual who has the responsibility to review the effectiveness of the individual controls is as follows:

[ ] Office Manager
[ ] Medical Assistant
[ ] Nurse Practitioner/Physician Assistant
[ ] Other: _____

Identification of the need for changes in engineering controls and work practices is made by review of OSHA records, employee interviews, and/or staff / committee activities. Both front line workers and management staff are involved in this process. Evaluation of new procedures and/or new products may be completed as necessary or as indicated based on current need.

Handwashing facilities are also available to the employees who incur exposure to blood or other potentially infectious materials. OSHA requires that these facilities be readily accessible after incurring exposure.

Handwashing facilities are located:

[ ] in each exam room
[ ] outside the exam room in hallway/alcove
[ ] in nurses station/lab room in close proximity to patient care area.
[ ] other: _____

If handwashing facilities are not feasible, the employer is required to provide either an antiseptic cleanser in conjunction with a clean cloth/paper towels or antiseptic towelettes. If these alternatives are used then the hands are to be washed with soap and running water as soon as feasibly possible. Employers who must provide alternatives to readily accessible handwashing facilities should list the locations, tasks and responsibilities to ensure maintenance and accessibility of these alternatives. Alternative locations/tasks and responsibilities are as follows:

[ ] N/A
[ ] Other: _____

After removal of personal protective gloves, employees shall wash hands and any other potentially contaminated skin area IMMEDIATELY or soon as feasibly possibly with soap and water.

If employees incur exposure to their skin or mucous membranes then those areas shall be washed or flushed with water as appropriate as soon as feasibly possible following contact.

NEEDLES

Contaminated needles and other contaminated sharps will not be bent, recapped, removed, sheared or purposely broken. Sharps means anything which can penetrate the skin including needles, scalpels, broken glass, broken capillary tubes and exposed ends of dental wires. Shearing or breaking of contaminated sharps is prohibited. Bending, recapping, or removing contaminated sharps, such as contaminated needles, is also prohibited unless there is no feasible alternative or such action is required by the specific medical procedure. If removal or recapping is necessary, removal or recapping must be done either by one-handed scooping (passive recapping) or through a recapping device.

DISPOSAL OF SHARPS AND REUSABLE SHARPS

Since reusable sharps, such as large bore needles, scalpels and saws pose the same percutaneous exposed hazard as disposable sharps, they must be contained in a manner that eliminates or minimizes the hazard until they are reprocessed. The container for disposing of reusables must meet the same standards as for disposable sharps. Sharps must be disposed as follows:

[X] Immediately or as soon as possible after use, all sharps must be placed in appropriate receptacles for reprocessing or disposal.
[X] Sharps must be located as close as possible to where sharps are used or can be reasonably anticipated to be found.
[X] Sharps containers must be maintained in an upright position throughout use, routinely replaced and not allowed to overfill.
[X] Medical assistant/provider will check the containers daily to determine if the container needs to be replaced/emptied.
[ ] For reusable sharps, a container system has been established which does not expose employees to the risk of percutaneous injury. No system involving the manual opening, emptying or cleaning of the container is allowed.
[ ] If the sharps container contains unwinders that separate needles from syringes, the employees will be trained with regard to proper removal of needles.

The sharps containers are puncture resistant, labeled with a biohazardous label and are leak proof. Sharps containers are located in the following places:

[ ] Each exam room
[ ] Nurses station
[ ] Lab and/or blood draw station
[ ] Triage/treatment room
[ ] Other: _____

The following employee(s) have the responsibility for removing sharps from containers/replacing full containers and for checking the containers for need to empty/replace on a daily basis:

[ ] Medical assistant
[ ] Nurse practitioner/physician assistant
[ ] Provider
[ ] Lab technician
[ ] Other: _____

WORK AREA RESTRICTIONS

In work areas where there is a reasonable likelihood of exposure to blood or other potentially infectious materials, employees are not to eat, drink, apply cosmetics or lip balm, smoke or handle contact lenses. Food and beverages are not to be kept in refrigerators, freezers, shelves, cabinets or on counter tops or bench tops where blood or other potentially infectious materials are present.

Mouthing pipetting/suctioning of blood or other potentially infectious materials is prohibited.

All procedures will be conducted in a manner which will minimize splashing, spraying, splattering and generation of droplets of blood or other potentially infectious materials. Methods which will be employed at this facility to accomplish this goal are as follows:

[ ] N/A
[ ] Cover on centrifuge
[ ] use of dental dams
[ ] Other: _____

SPECIMENS

Specimens of blood or other potentially infectious materials will be placed in a container which prevents leakage during the collection, handling, processing, storage, and transport of the specimens.

The container used for this purpose will be labeled or color coded in accordance with the requirements of the OSHA standard.

(Employers should note that the standard provides for an exemption for specimens from the labeling/color coding requirement of the standard provided that the facility utilizes universal precautions in the handling of all specimens and the containers are recognizable as containing specimens. This exemption applies only while the specimens remain in the facility). If the employer chooses to use this exemption then it should be stated below:

[ ] N/A
[ ] _____

Any specimens which could puncture a primary container will be placed within a secondary container which is puncture resistant. (List here how this will be carried out, e.g. which specimens, if any, could puncture a primary container, which containers can be used as a secondary containers and where the secondary containers are located at the facility).

[ ] N/A
[ ] Explanation: _____

_____

If outside contamination of the primary container occurs, the primary container shall be placed within a secondary container which prevents leakage during the handling, processing, storage, transport, or shipping of the specimen.

CONTAMINATED EQUIPMENT

Equipment which has become contaminated with blood or other potentially infectious materials shall be examined prior to servicing or shipping and shall be decontaminated as necessary unless the decontamination of the equipment is not feasible. (List here any equipment which it is felt can not be decontaminated prior to servicing).

[ ] N/A
[ ] list equipment: _____

_____

PERSONAL PROTECTIVE EQUIPMENT

All personal protective equipment used at this facility will be provided without cost to employees. Personal protective equipment will be chosen based on the anticipated exposure to blood or other potentially infectious materials. The protective equipment will be considered appropriate only if it does not permit blood or other potentially infectious materials to pass through or reach the employees' clothing, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.

1. Disposable gloves: Employees must wear appropriate gloves when it can be reasonably anticipated that the employee may have contact with blood (eg: suturing, immunizations, etc.) and other potentially infectious materials and when handling or touching contaminated items or surfaces. Gloves shall be replaced if torn, punctured, contaminated or deteriorated. Disposable gloves are located in:

   [ ] exam rooms/treatment rooms
   [ ] nurses station/ lab area
   [ ] blood draw station/room
   [ ] other: _____

Disposable gloves must be worn when performing the following procedures:

[ ] blood draws/venipuntures
[ ] performing blood testing (eg: hematocrit/hemoglobin etc.)
[ ] cleaning blood /potentially infectious material spills
[ ] cleaning dirty/contaminated instruments
[ ] pap smears/assist with pap smears
[ ] minor surgeries/suturing
[ ] any specimen handling
[ ] caring for isolation patients
[ ] other: _____
[ ] other: _____

2. Utility gloves: Utility Gloves (ie: housekeeping) may be decontaminated for re-use if the integrity of the glove is not compromised. However, they must be discarded if they are cracked, peeling, torn, punctured or exhibit other signs of deterioration. Check utility gloves for cracks or other flaws as noted above and replace as necessary. Utility Gloves are located:

[ ] N/A
[ ] with housekeeping supplies in housekeeping closet/cabinet
[ ] other: _____

Utility gloves will be worn when performing the following procedures:

[ ] Housekeeping duties
[ ] cleaning toilets/sinks/floors etc.
[ ] Other _____

3. Masks, eye protection and face shields: Employees must wear masks, eye protection and/or face shields to protect the mucous membranes of the face and upper respiratory tract from droplet splattering. Minimum protection should consist of a mask in conjunction with eye glasses (goggles) with side shields or a chin length face shield. Masks/eye protection and / or face shield will be worn when performing the following procedures:

[ ] washing contaminated/dirty instruments
[ ] other: _____
[ ] other: _____
[ ] other: _____

4. Protective clothing: Use of protective body clothing such as gowns, aprons, lab coats, clinic jackets, surgical caps, or shoe covers and the degree to which such protective equipment must resist penetration, are performance based. The tasks and the type of exposure anticipated has been evaluated and, based on the determination, the following appropriate personal protective clothing is required:

[ ] Barrier proof gown
[ ] apron
[ ] lab coat
[ ] clinic coat
[ ] shoe cover
[ ] surgical cap
[ ] other: _____
[ ] other: _____

The above noted items will be worn when performing the following procedures:

[ ] N/A
[ ] when washing contaminated/dirty instruments
[ ] other: _____
[ ] other: _____

All personal protective equipment will be cleaned, laundered, and/ or disposed of by the employer at no cost to the employees. All repairs and replacements will be made by the employer at no cost to employees.

All garments which are penetrated by blood shall be removed immediately or as soon as feasibly possible. All personal protective equipment will be removed prior to leaving the work area. The following protocol has been developed to facilitate leaving the equipment at the work area: (list where employees are expected to place the personal protective equipment upon leaving the work area, and other protocols, etc.).

[ ] All personal protective equipment is disposable and will be discarded in biohazardous waste in exam/treatment room.
[ ] other: _____

HOUSEKEEPING

Medical facilities must be maintained in a clean and sanitary condition. The Facility will be cleaned and decontaminated according to the following schedule and/or as follows:

[ ] Please see attached housekeeping schedule

[X] Work surfaces will be decontaminated with an appropriate disinfectant after completion of procedures, immediately when overtly contaminated, after any spill of any blood or other potentially infectious materials and at the end of the work shift when surfaces have become contaminated since the last cleaning.

[ ] Protective coverings, such as plastic wrap, aluminum foil or imperviously-backed absorbent paper, will be used to cover equipment and surfaces when they have become overtly contaminated and at the end of a work shift if they have become contaminated during the shift.

[X] Reusable receptacles, such as bins, pails and cans that have a likelihood for becoming contaminated, will be inspected and decontaminated on a daily basis. When contamination is visible, receptacles will be cleaned and decontaminated immediately or as soon as is feasible.

[X] Broken glassware which may be contaminated will not be picked up directly with the hands. A dust pan and hand broom will be used to sweep up the broken glass. The tools used in the clean up of broken glass will be decontaminated or discarded after use and the broken glass will be placed in a sharps container. Vacuum cleaners are not appropriate for cleanup of contaminated broken glass.

[ ] Sorting or rinsing of contaminated laundry will not be performed in patient care areas. Contaminated laundry will be placed and transported in bags or containers labeled in accordance with labeling requirements set forth in section "labeling". In addition, laundry which is saturated will be placed in leak-proof bags.

[ ] If the facility to which laundry is shipped does not utilize universal precautions, all bags or containers of contaminated laundry will be labeled or color coded. All employees who have contact with contaminated laundry will wear protective gloves and other appropriate personal protective devices.

[ ] Laundry is sent off site for cleaning. The laundry service accepting the laundry is notified in accordance with section (d) of the standard.

The personnel responsible for the above duties indicated by [X] are as follows:

[ ] Medical assistant
[ ] Housekeeping personnel
[ ] Other _____

REGUALTED WASTE DISPOSAL

Regulated waste requires special handling and will be placed in appropriate containers. Regulated waste includes the following: 1.) liquid or semi-liquid blood or other potentially infectious material, 2.) items contaminated with blood or other potentially infectious material that would release these substances in a liquid or semi-liquid state if compressed, 3.) items that are caked with blood or other potentially infectious material and are capable of releasing these materials during handling, 4.) contaminated sharps and 5.) pathologic and microbiological wastes containing blood or other potentially infectious material.

The containers into which regulated wastes is stored, transported or shipped will be closable. The container will also be constructed so as to contain the waste and prevent leakage of its contents. If the waste could puncture the primary container, the primary container must be placed into a puncture resistant secondary container. If outside contamination of the primary container occurs, the primary container will also be placed within a second container which

prevents leakage. For containment requirements of sharps see the section "disposal of sharps and contaminated sharps" above. Regulate waste other than sharps will be placed in appropriate containers lined with red bags.

These biohazardous waste containers are located:

[ ] in each exam room
[ ] treatment room
[ ] lab draw station
[ ] nurses station

HEPATITIS B VACCINE

All employees who have been identified as having exposure to blood or other potentially infectious materials will be offered the Hepatitis B vaccine, at no cost to the employee. The vaccine will be offered within 10 working days of their initial assignment to work involving the potential for occupational exposure to blood or other potentially infectious materials unless the employee has previously had the vaccine or who wishes to submit to antibody testing which shows the employee to have sufficient immunity.

Employees who decline the Hepatitis B vaccine will sign a waiver which uses the wording in Appendix A of the OSHA standard.

Employees who initially decline the vaccine but who later wish to have it may then have the vaccine provided at no cost.

The following individual has responsibility for assuring that the vaccine is offered, the waivers are signed, the vaccine is administered, etc.

[ ] Office manager
[ ] Provider/physician
[ ] Name of person: _____

POST EXPOSURE EVALUATION AND FOLLOW UP

When the employee incurs an exposure incident, it should be reported to:

[ ] Office Manager
[ ] Physician
[ ] Administrator
[ ] Name of person: _____

All employees who incur an exposure incident will be offered post-exposure evaluation and follow-up in accordance with the OSHA standard.

This follow-up will include the following:

- Documentation of the route of exposure and the circumstances related to the incident.
- If possible, the identification of the source individual and if possible, the status of the source individual will be tested (after consent is obtained) for HIV/HBV infectivity.

- Results of testing of the source individual will be made available to the exposed employee with the exposed employee informed about the applicable laws and regulations concerning disclosure of the identity and infectivity of the source individual. (Employers may need to modify this provision in accordance with applicable local laws on this subject. Modifications should be listed here:

  [ ] N/A
  [ ] Explain modifications: _____

  _____

  _____

- The employee will be offered the option of having their blood collected for testing of the employee HIV/HBV serological status. The blood sample will be preserved for up to 90 days to allow the employee to decide if the blood should be tested for HIV serological status. However, if the employee decides prior to that time that testing will or will not be conducted then the appropriate action can be taken and the blood sample discarded. The employee will be offered post exposure prophylaxis in accordance with the current recommendations of the U.S. Public Health Service. These recommendations are currently as follows: (These recommendations may be listed as an appendix to the plan)

  [X] See attached appendix titled "post exposure prophylaxis".

- The employee will be given appropriate counseling concerning precautions to take during the period after the exposure incident. The employee will also be given information on what potential illnesses to be alert for and to report any related experiences to appropriate personnel. The following person(s) has been designated to assure that the policy outlined here is effectively carried out as well as to maintain records related to this policy:

  [ ] Office manager
  [ ] Physician
  [ ] Administrator
  [ ] Name of person: _____

INTERACTION WITH HEALTH CARE PROFESSIONALS

A written opinion shall be obtained from the health care professional who evaluates employees of this facility. Written opinions will be obtained in the following instances:

1) When the employee is sent to obtain the Hepatitis B vaccine.

2) Whenever the employee is sent to a health care professional following an exposure incident.

Health care professionals shall be instructed to limit their opinions to:

1) Whether the Hepatitis B vaccine is indicated and if the employee has received the vaccine, or for evaluation following an incident.

2) That the employee has been informed of the results of the evaluation, and

3) That the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials. (Note that the written opinion to the employer is not to reference any personal medical information).

TRAINING

Training for all employees will be conducted prior to initial assignment to tasks where occupational exposure may occur. Training will be conducted in the following manner:

Training for employees will include the following an explanation of:

1) The OSHA standard for Bloodborne Pathogens

2) Epidemiology and symptomatology of bloodborne diseases

3) Modes of transmission of bloodborne pathogens

4) This Exposure Control Plan, i.e. points of the plan, lines of responsibility, how the plan will be implemented, etc.)

5) Procedures which might cause exposure to blood or other potentially infectious materials at this facility

6) Control methods which will be used at the facility to control exposure to blood or other potentially infectious materials.

7) Personal protective equipment available at this facility and who should be contacted concerning

8) Post Exposure evaluation and follow-up

9) Signs and Labels used at the facility

10) Hepatitis B vaccine program at the facility

RECORDKEEPING

All records required by the OSHA standard will be maintained by: The following person/department is responsible for maintaining records:

[ ] Office Manager
[ ] Physician
[ ] Administration department
[ ] Other _____

DATES

All provisions required by the standard will be implemented by:

[ ] (date for implementation of the provisions of the standard) _____

Training will be conducted using:

[ ] videotapes
[ ] written materials
[ ] Inservice class instruction
[ ] Other: _____

The following person will be responsible for ensuring training is completed or for conducting training:

[ ] Nurse/Nurse Practitioner
[ ] Physician Assistant
[ ] Physician
[ ] Office Manager/Administrator
[ ] Other: _____

All employees will receive annual refresher training. Note that this training is to be conducted within one year of the employee's previous training.

The outline for the training material is located (list where the training materials are located):
[ ] Located in the FSR Resource Binder
[ ] Located in the Policy and Procedure Manual
[ ] Located in the Inservice Education Binder/Folder/Manual
[ ] Other: _____

APPENDIX

POST EXPOSURE PROPHYLAXIS (PEP)

These recommendations are taken from
Exposure to Blood What Heatlhcare Personnel Need to Know
Updated July 2003
Department of Health and Human Services
Centers for Disease Control and Prevention

Treatment for exposure to HBV:
All health care personnel who have a reasonable chance of exposure to blood or body fluids should receive a hepatitis B vaccine. Vaccination ideally should occur during the healthcare worker's training period. Workers should be tested 1-2 months after the vaccine series is complete to make sure the vaccination has provided immunity to HBV infection. Hepatitis B immune globulin (HBIG) alone or in combination with vaccine (if not previously vaccinated) is effective in preventing HBV infection after exposure. The decision to begin treatment is based on several factors such as:

1.) Whether the source individual is positive for hepatitis B surface antigen
2.) Whether exposed individual has been vaccinated
3.) Whether the vaccine provided the exposed individual immunity

Treatment for exposure to HCV:
There is no vaccine against hepatitis C and no treatment after an exposure that will prevent infection. Neither immune globulin nor antiviral therapy is recommended after exposure. For these reasons, following recommended infection control practices to prevent percutaneous injuries is imperative.

Treatment for exposure to HIV:
There is no vaccine against HIV. However, results from a small number of studies suggest that the use of some antiretroviral drugs after certain occupational exposures may reduce the chance of HIV transmission. Post exposure prophylaxis (PEP) is recommended for certain occupational exposures that pose a risk of transmission. However, for those exposures without risk of HIV infection, PEP is not recommended because the drugs used to prevent infection may have serious side effects. Exposed individual should discuss the risks and side effects with his/her healthcare provider before starting PEP for HIV.

Exposures to blood from an individual whose infection status is unknown:

HBV-HCV-HIV
If the source individual cannot be identified or tested, decisions regarding follow up should be based on the exposure risk and whether the source is likely to be infected with a bloodborne

pathogen. Follow-up testing should be available to all personnel who are concerned about possible infection through occupational exposure.

Specific drugs recommended for post exposure treatment:

HBV
If the exposed individual has not been vaccinated, then hepatitis B vaccination is recommended for any exposure regardless of the source person's HBV status. HBIG and/or hepatitis B vaccine may be recommended depending on the source person's infection status, the exposed person's vaccination status and, if vaccinated, the exposed person's response to the vaccine.

HCV
There is no post exposure treatment that will prevent HCV infection.

HIV
The Public Health Service recommends a 4 week course of a combination of either two antiretroviral drugs for most HIV exposures, or three antiretroviral drugs for exposures that may pose a greater risk for transmitting HIV (such as those involving a larger volume of blood with a larger amount of HIV or a concern about drug resistant HIV). Differences in side effects associated with the use of these drugs may influence which drugs are selected in a specific situation. These recommendations are intended to provide guidance to clinicians and may be modified on a case by case basis. Determining which drugs and how many drugs to use or when to change a treatment regimen is largely a matter of judgement. Whenever possible, consulting an expert with experience in the use of antiretroviral drugs will be done, especially if a recommended drug is not available, if the source person's virus is likely to be resistant to one or more recommended drugs, or if the drugs are poorly tolerated.

When to start PEP:

HBV
Post exposure treatment should begin as soon as possible after exposure, preferably within 24 hours, and no later than 7 days.

HIV
Treatment should be started as soon as possible, preferably within hours as opposed to days, after the exposure. Although animal studies suggest that treatment is less effective when started more than 24-36 hours after exposure, the time frame after which no benefit is gained in humans is not known. Starting treatment after a longer period (e.g. 1 week) may be considered for exposures that represent in increased risk of transmission.

PEP for pregnant healthcare workers:

HBV
Women who are pregnant or breast-feeding can receive the hepatitis B vaccine and/or HBIG. Pregnant women who are exposed to blood should be vaccinated against HBV infection, because infection during pregnancy can cause severe illness in the mother and a chronic infection in the newborn. The vaccine does not harm the fetus.

HIV
Pregnancy should not rule out the use of post exposure treatment when it is warranted. If the exposed individual is pregnant he/she should understand what is known and not known regarding the potential benefits and risks associated with the use of anti-viral drugs in order to make an informed decision about treatment.

Follow up after exposure:

HBV
Because post exposure treatment is highly effective in preventing HBV infection, CDC does not recommend routine follow up after treatment. However, any symptoms suggesting hepatitis (e.g. yellow eyes or skin, loss of appetite, nausea, vomiting, fever, stomach or joint pain, extreme tiredness) should be reported to the healthcare provider. If hepatitis B vaccine is given, the individual should be tested 1-2 months after completing the vaccine series to determine if the individual has responded to the vaccine and is protected against HBV infection.

HCV
The individual should be tested for HCV antibody and liver enzyme levels (alanine aminotransferase or ALT) as soon as possible after the exposure (baseline) and at 4-6 months after exposure. To check for infection earlier, the individual can be tested for the virus (HCV RNA) 4-6 weeks after exposure. Report any symptoms suggesting hepatitis (mentioned above) to the health care provider.

HIV
The individual should be tested for HIV antibody as soon as possible after exposure (baseline) and periodically for at least 6 months after the exposure (e.g. at 6 weeks, 12 weeks, and 6 months). If the individual is taking antiviral drugs for post exposure treatment, he/she should be checked for drug toxicity by having a complete blood count and kidney and liver function tests just before starting treatment and 2 weeks after starting treatment. An sudden or severe flu like illnesses that occurs during the follow up period, especially if it involves fever, rash, muscle aches, tiredness, malaise, or swollen glands should be reported. Any of these may suggest HIV infection, drug reaction, or other medical conditions. The healthcare provider should be contacted for any questions or problems during the follow up period.

Precautions to take during the follow up period:

HBV
No precautions are necessary.

HCV

No precautions are recommended secondary to a low risk of becoming infected and passing the infection on to others.

HIV

During the follow-up period, especially the first 6-12 weeks when most infected persons are expected to show signs of infection, the following recommendations for preventing transmission of HIV should be followed. These recommendations include not donating blood, semen or organs and not having sexual intercourse. If the individual chooses to have sexual intercourse, using a condom consistently and correctly may reduce the risk of HIV transmission. In addition, women should consider not breast feeding infants during the follow up period to prevent the possibility of exposing the infant to HIV that may be in breast milk.

PCP	Page 1 of 1
Section: Infection Control	
POLICY AND PROCEDURE: Decontamination of Surfaces	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:_____

POLICY:

The site will follow decontamination procedures on contaminated surfaces according to Cal-OSHA Standards, 8 CCR §5193; CA H&S Code §118275. The site will utilize products from the Current EPA product lists and information available from the EPA, Antimicrobial Division (703) 305-1284 or (703) 308-0127.

PROCEDURE:

I. ROUTINE DECONTAMINATION

A. Contaminated work surfaces are decontaminated with an appropriate disinfectant (29 CFR 1910.1030). Written "housekeeping" schedules have been established and are followed for regular routine daily cleaning. Staff is able to identify frequency for routine cleaning of surfaces and equipment, the disinfectant used and responsible personnel.

II. SPILL PROCEDURE

A. Staff is able to identify procedures for prompt decontamination of blood/body fluid spills, the disinfectant used, and the responsible person(s).

Ill. DISINFECTANT PRODUCTS

A. Products used for decontamination have a current EPA-approved status. Product will effectively kill HIV/HBV/TB. If manufacturer's product label indicates it will kill TB, it is understood that product will effectively kill HIV and HBV. Decontamination products are reconstituted and applied according to manufacturer's guidelines for "decontamination."

IV. 10% BLEACH SOLUTION

A. If 10% bleach solution is used, it is changed/reconstituted every 24 hours (Due to instability of bleach once mixed with water). Surface is cleaned prior to disinfecting [due to presence of organic matter (e.g., dirt, blood, excrement) inactivates active ingredient, sodium hypochlorite]. Surface is air dried or allowed appropriate time (stated on label) before drying. Manufacturer's directions, *specific* to every bleach product, are followed carefully.

BLEACH COMPARISON CHART

Brand of Bleach	CDC APPROVED TUBERCULOCIDAL DISINFECTANT	% of Sodium Hypochlorite	Label Instructions for Professional Disinfection	Contact Time	Additional Customer Service/Website Comments	EPA Registered	Warning Label
Clorox Germicidal	✓	6.15%	Mix 1 part bleach with 9 parts water = 10% "Tuberculocidal"	5 mins	"Tuberculocidal"	Yes	**Corrosive**
Clorox Regular	✓	6%	Mix ¾ cup bleach with 1 gallon water = 4.5%	5 mins	Mix 1¾ cup bleach with 1 gallon water = 9.86% "Tuberculocidal"	Yes	**Corrosive**
First Street Ultra Germicidal (Smart & Final)	✓	6%	Mix ¾ cup bleach with 1 gallon water = 4.5%	5 mins	"Tuberculocidal"	Yes	**Corrosive**
Everyday Life (Ralphs)	✓	6%	Mix ¾ cup bleach with 1 gallon water = 4.5%	5 mins		Yes	**Corrosive**
Up & Up (Target)	✓	6%	Mix ¾ cup bleach with 1 gallon water = 4.5%	5 mins		Yes	**Corrosive**
Clorox Splash-less		6%	For laundry and household cleaning only		"NOT a professional disinfectant due to added thickeners"		Eye Irritant
Clorox Scented		2.75%	For laundry and household cleaning only				Eye Irritant
Simply Value (Smart & Final)		2.75%	For laundry and household cleaning only				Eye Irritant
Rinso (99 Cents Only Store)		not specified	For laundry and household cleaning only				Eye Irritant
Clorox Clean-Up Spray w/ Bleach		1.85%	Spray on affected surface	30 sec	"NOT tuberculocidal"	Yes	Eye Irritant

*CDC Guidelines for Disinfection in Healthcare Facilities, 2008:

1. By law, all applicable label instructions on EPA-registered products must be followed.
2. Disinfect areas contaminated with blood spills using an EPA-registered tuberculocidal agent or freshly diluted hypochlorite solution (bleach).
3. If sodium hypochlorite solutions are selected, use 5.25 – 6.25% sodium hypochlorite to decontaminate non-porous surfaces after a spill of either blood or other potentially infectious materials (OPIM).

DPerlas

THE CLOROX COMPANY

As of February 12, 2014

Clorox Healthcare® Bleach Germicidal Cleaner
(Previously known as Dispatch Hospital Cleaner Disinfectant with Bleach)
Update on TB & C. difficile spore Claims

Clorox Healthcare has voluntarily removed the claim for TB as well as the claim for C. difficile spores from the product label of all Clorox Healthcare® Bleach Germicidal Cleaner items (formerly known as Dispatch Hospital Cleaner Disinfectant with Bleach). This decision was made due to the results of spot testing completed by the EPA's Antimicrobial Testing Program for efficacy against Mycobacterium Bovis (TB) and C. diff spores. Please note that the removal of these claims only applies to the Clorox Healthcare Bleach Germicidal Cleaner items (liquid spray, liquid pull top and refill liquids) and does not impact Clorox Healthcare® Bleach Germicidal Wipes or Dispatch Wipes.

While this process was initially expected to be resolved in a short period of time, the process has taken longer than expected due to continued discussion regarding testing differences along with the temporary government shutdown. Clorox Healthcare is working with the EPA to resolve these issues and we are optimistic that both of these claims will be back on the product label in the future.

Clorox Healthcare® Bleach Germicidal Cleaner (previously known as Dispatch Hospital Cleaner Disinfectant with Bleach) has had an EPA-registered TB claim for over 5 years and C. diff spore claim for 3 years. The product active of Clorox Healthcare® Bleach Germicidal Cleaner has not changed during this time and still features a 1:10 dilution of bleach.

If your facility must have a product with an EPA-registered TB and/or C. difficile spore claim, please reference page 2 of this document for a list of Clorox Healthcare items EPA-registered to kill C. diff spores and TB.

Sincerely,

Matt Laszlo
Vice-President General Manager
Clorox Professional Products Company

TheCloroxCompany.com 4900 Johnson Drive / Pleasanton, California 94588-8004 / 925-368-6000

Clorox Healthcare items EPA-registered to kill C. diff spores

Item #	Product Description	Contact Time
35309	Clorox Healthcare Bleach Germicidal Wipes 6/70ct	3 minutes
30358	Clorox Healthcare Bleach Germicidal Wipes 2/110ct	3 minutes
30359	Clorox Healthcare Bleach Germicidal Wipes Refill 2/110ct	3 minutes
30577	Clorox Healthcare Bleach Germicidal Wipes 6/150ct	3 minutes
69150	Dispatch Hospital Cleaner Disinfectant Towels w/Bleach 8/150ct	5 minutes
69101	Dispatch Hospital Cleaner Disinfectant Towels w/Bleach 6/50ct	5 minutes
69260	Dispatch Hospital Cleaner Disinfectant Towels w/Bleach 12/60ct	5 minutes
69240	Dispatch Hospital Cleaner Disinfectant Towels w/Bleach 24/40ct	5 minutes
30966	Clorox Bleach Liquid Commercial Solutions Germicidal Concentrated 3/121fo	5 minutes
31009	Clorox Bleach Liquid Commercial Solutions Germicidal Concentrated 8/64fo	5 minutes

Clorox Healthcare items EPA-registered to kill TB

Item #	Product Description	Contact Time
35309	Clorox Healthcare Bleach Germicidal Wipes 6/70ct	3 minutes
30358	Clorox Healthcare Bleach Germicidal Wipes 2/110ct	3 minutes
30359	Clorox Healthcare Bleach Germicidal Wipes Refill 2/110ct	3 minutes
30577	Clorox Healthcare Bleach Germicidal Wipes 6/150ct	3 minutes
69150	Dispatch Hospital Cleaner Disinfectant Towels w/Bleach 8/150ct	2 minutes
69101	Dispatch Hospital Cleaner Disinfectant Towels w/Bleach 6/50ct	2 minutes
69260	Dispatch Hospital Cleaner Disinfectant Towels w/Bleach 12/60ct	2 minutes
69240	Dispatch Hospital Cleaner Disinfectant Towels w/Bleach 24/40ct	2 minutes
30828	Clorox Healthcare Hydrogen Peroxide Cleaner Disinfectant 9/32fo	4 minutes
30829	Clorox Healthcare Hydrogen Peroxide Cleaner Disinfectant 4/128fo	4 minutes
30825	Clorox Healthcare Hydrogen Peroxide Cleaner Disinfectant Wipes 6/155ct	5 minutes
30824	Clorox Healthcare Hydrogen Peroxide Cleaner Disinfectant Wipes 6/95ct	5 minutes
30826	Clorox Healthcare Hydrogen Peroxide Cleaner Disinfectant Wipes 2/185ct	5 minutes
30827	Clorox Healthcare Hydrogen Peroxide Cleaner Disinfectant Wipes Refill 2/185ct	5 minutes
30649	Clorox Broad Spectrum Quaternary Disinfectant Cleaner Spray 9/32fo	5 minutes
30651	Clorox Broad Spectrum Quaternary Disinfectant Cleaner Refill 4/128fo	5 minutes
30966	Clorox Bleach Liquid Commercial Solutions Germicidal Concentrated 3/121fo	5 minutes
31009	Clorox Bleach Liquid Commercial Solutions Germicidal Concentrated 8/64fo	5 minutes

Clorox® Germicidal Bleach[1]

The Brand You Can Trust.

Clorox® Germicidal Bleach is new and improved with a concentration of 8.25%.

Clorox® Germicidal Bleach[1]

(3/121 fl. oz. & 8/64 fl. oz.)

Clorox Germicidal Bleach[1] Is Effective Against Common Germs, Viruses and Bacteria*

View All

®

Bacteria

Effective Against:	Kill Time
Acinetobacter baumannii	5 minutes
Clostridium difficile spores	5 minutes
Vancomycin-resistant *Enterococcus faecalis* (VRE)	5 minutes
Escherichia coli O157:H7	5 minutes
ESBL-producing *Escherichia coli*	5 minutes
Legionella pneumophila	5 minutes
Pseudomonas aeruginosa	10 minutes
Salmonella enterica	5 minutes
Shigella dysentriae	5 minutes
Staphylococcus aureus	5 minutes
Methicillin-resistant *Staphylococcus aureus* (MRSA)	5 minutes
Methicillin-resistant Staphylococcus aureus (CA-MRSA)(USA 400)	5 minutes
Streptococcus pneumonia	5 minutes
Streptococcus pyogenes	5 minutes

Section: Infection Control	
POLICY AND PROCEDURE: Standard and Universal Precautions	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date :_____ Revised Date:_____

POLICY:

Infection Control standards are practiced on site to minimize risk of disease transmission. Site personnel will apply the principles of "Standard Precautions" (CDC, 1996), used for all patients regardless of infection status. Standard precautions apply to blood, all body fluids, non-intact skin, and mucous membranes, which are treated as potentially infectious for HIV, HBV or HCV, and other blood borne pathogens. "Universal precautions" refer to the OSHA mandated program that requires implementation of work practice controls, engineering controls, blood borne pathogen orientation/education, and record keeping in healthcare facilities.

PROCEDURE:

I. HAND WASHING FACILITIES

A. Hand washing facilities are available in the exam room and/or utility room, and include an adequate supply of running potable water, soap and single use towels or hot air drying machines. Sinks with a standard faucet, foot- operated pedals; 4-6-inch wing-type handle, automatic shut-off systems or other types of water flow control mechanism are acceptable. Staff is able to demonstrate infection control "barrier" methods used on site to prevent contamination of faucet handle, door handles and other surfaces until hand washing can be performed. On occasions when running water is not readily available, an antiseptic hand cleanser, alcohol-based hand rub, or antiseptic towelettes is acceptable until running water is available (29 CFR 1919.1030).

B. Hand washing prevents infection transmission by removing dirt, organic material and transient microorganisms from hands. Hand washing with plain (non-antimicrobial) soap in any form (e.g., bar, leaflet, liquid, powder, granular) is acceptable for general patient care (Association for Professionals in Infection Control and Epidemiology, Inc., 1995).

II. Antiseptic Hand Cleaner

A. Antimicrobial agents or alcohol-based antiseptic hand rubs are used for hand washing when indicated to remove debris and destroy transient microorganisms (e.g., before performing invasive procedures, after contact with potentially infectious materials). Plain and antiseptic hand wash products are properly maintained and/or dispensed to prevent contamination.

Ill. WASTE DISPOSAL CONTAINER

A. Contaminated wastes (e.g. dental drapes, band aids, sanitary napkins, soiled disposal diapers) are disposed of in regular solid waste (trash) containers, and are maintained to prevent potential contamination of patient/staff areas and/or unsafe access by infants/children.

IV. ISOLATION PROCEDURES

A. If you suspect that a patient may have a communicable disease you
    a. Take the patient immediately to the closest exam room, place the patient in the exam room and close the door completely.
    b. Immediately notify the physician or on site practitioner of the situation and request that they see the patient as quickly as possible.
    c. Wipe the reception counter down with disinfectant cleaning solution and continue seeing patients.

B. If the practitioner indicates that the patient **DOES NOT** have a communicable disease, clean the room as usual between patients and continue to use the room.

C. If the practitioner indicates that the patient **DOES** have a communicable disease
    a. Follow the practitioner's directions and orders without variation.
    b. If the practitioner indicates that the patient needs a mask make certain that you have put on the personnel protective gown, gloves, mask, goggles from your PPE Kit(Spill Kit)
    c. Assist the patient with placing the mask on correctly and escort the patient to the closest exit door preferably not through the waiting room.
    d. Keep the exam room door closed when you leave.
    e. Return to the room with the necessary cleaning solution and materials and equipment. Keep the room door closed while cleaning the room.
    f. Be certain to dispose of all trash, exposed disposable items, etc in a red leak proof Biohazard bag. This includes the protective gown, mask, gloves and hair cover you are wearing while cleaning the room. Seal the bag.
    g. Clean all surfaces in the room with the cleaning solution, do not wipe dry, and let the room air dry ensuring that the surfaces stay wet for the contact time indicated by the manufacturer on the container label.
    h. Have a co-worker bring a second red bag to the room door and wearing gloves hold the bag open.
    i. Place the bag from the room into the second bag, being careful not to touch your co-worker with the bag.

j. Your Co-worker places their gloves in the bag and closes the bag tightly and places it directly into the biohazard storage area.
k. When the contact time has been exceeded and the surfaces are dry you can open the room, remake the exam table and continue to use the room.

State of California—Health and Human Services Agency

What do you eat?

Department of Health Care Services

What did you eat yesterday? List everything you ate and drank. How much? What time?

Time	Amount	Food or Drink
10:00 a.m.	½ cup	Carrots

Was yesterday a typical day? _____Yes _____No

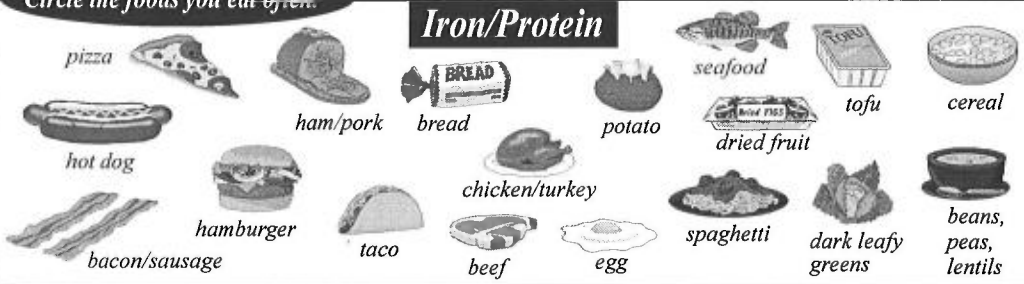
For office use only

(Check (✓) topics discussed)

- ☐ Continue eating healthy
- ☐ ⬆ regular meals/snacks
- ☐ Encourage breakfast
- ☐ Inadequate food supply
- ☐ Encourage lower fat
- ☐ Encourage lower sugar
- ☐ Weight management
- ☐ Disordered eating
- ☐ Other_____

Circle the foods you eat ~~often~~.

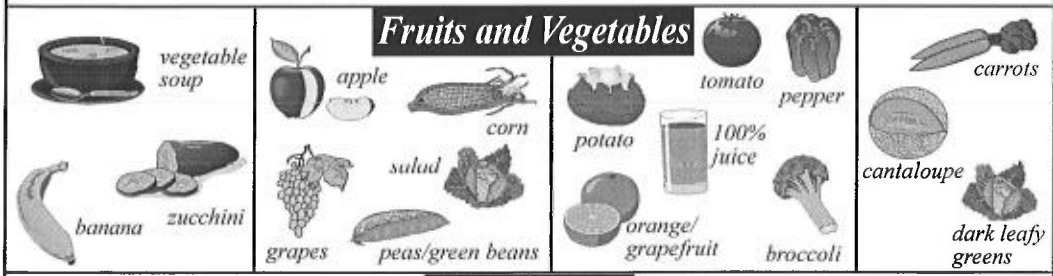
Iron/Protein



Iron/Protein

- ☐ 2 - 3 servings daily
- ☐ ⬆ high iron foods
- ☐ ⬆ alternate protein sources for vegetarian diets
- ☐ ⬆ beans, lentils, peas
- ☐ Limit high fat meats

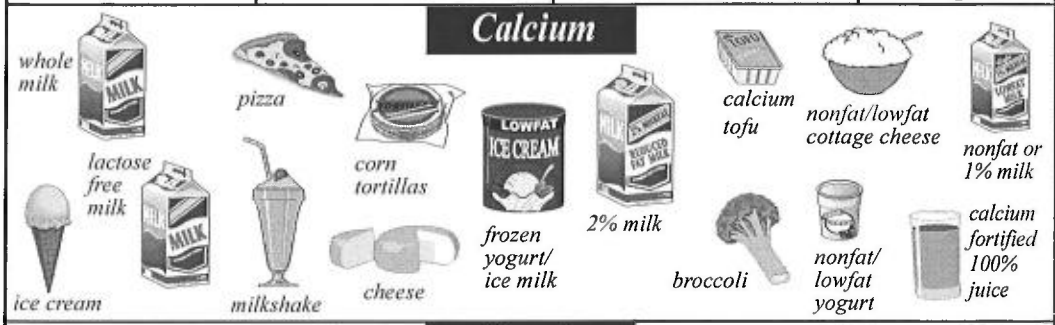
Fruits and Vegetables



Fruits and Vegetables

- ☐ 2 - 4 Fruits daily or more
- ☐ 3 - 5 Vegetables daily or more
- ☐ Vitamin C sources
- ☐ Vitamin A sources

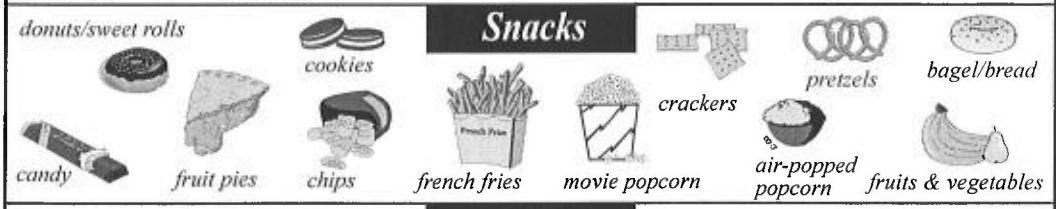
Calcium



Calcium

- ☐ 3 - 4 servings daily
- ☐ Encourage nonfat or 1% milk
- ☐ ⬇ high fat choices
- ☐ ⬆ low lactose alternatives
- ☐ ⬆ calcium-fortified foods

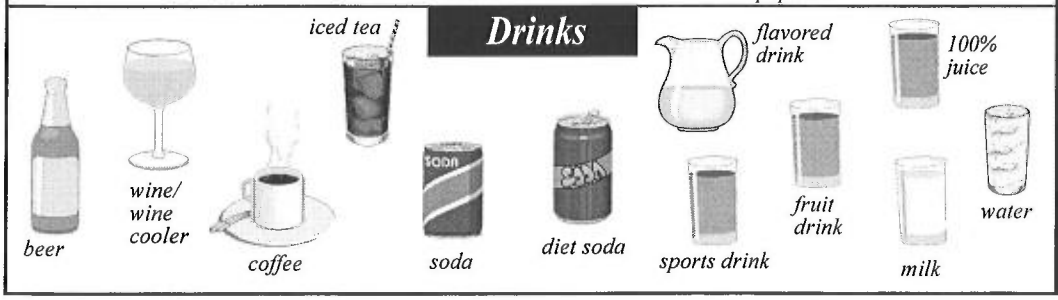
Snacks



Snacks

- ☐ ⬇ high sugar snacks
- ☐ ⬇ high fat snacks
- ☐ ⬆ fruit/vegetable snacks
- ☐ ⬇ fast food

Drinks



Drinks

- ☐ Limit juice: 1/day (4-8 oz. total)
- ☐ Drink 100% juice
- ☐ Drink 8-12 glasses water/day (8 oz. each)
- ☐ Discourage fruit drinks
- ☐ Discourage soda/caffeine
- ☐ Discourage alcohol

0306.132.H49

Name_____ **Age**_____ **Date of Birth**_____ **Date**_____

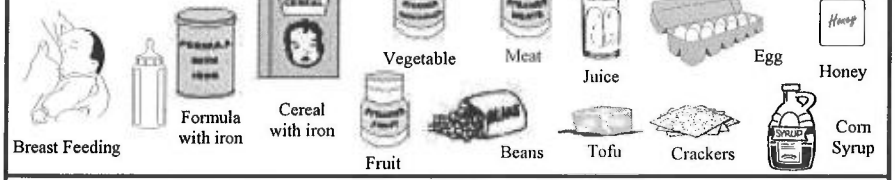
State of California—Health and Human Services Agency

Department of Health Care Services
Child Health and Disability Prevention (CHDP) Program

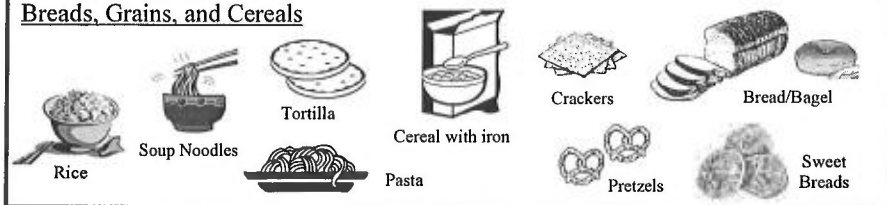
What Does Your Child Eat?

Circle the foods your child *eats* every day or at least 3 times per week:

Baby Foods

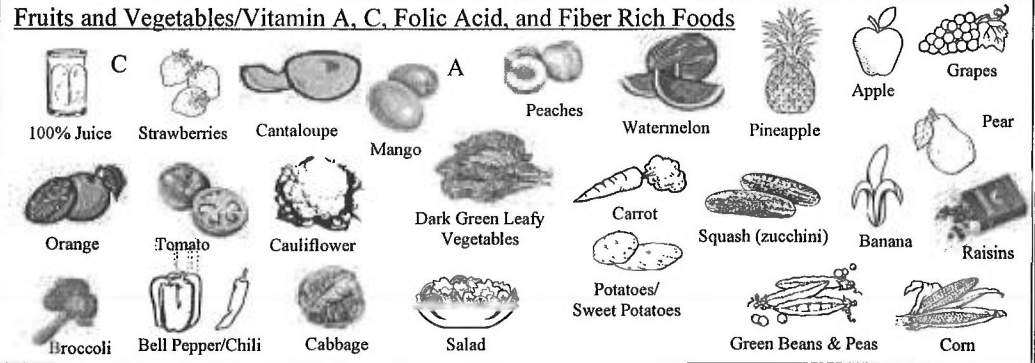


Breads, Grains, and Cereals

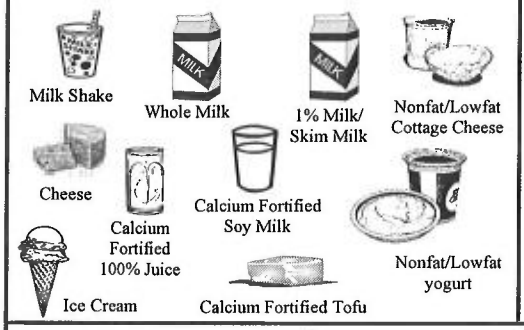


How does your child feel about mealtimes?

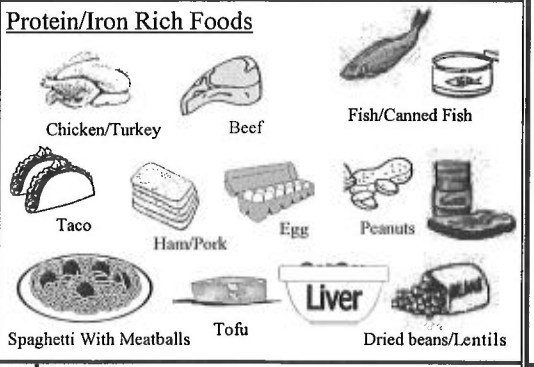
Fruits and Vegetables/Vitamin A, C, Folic Acid, and Fiber Rich Foods



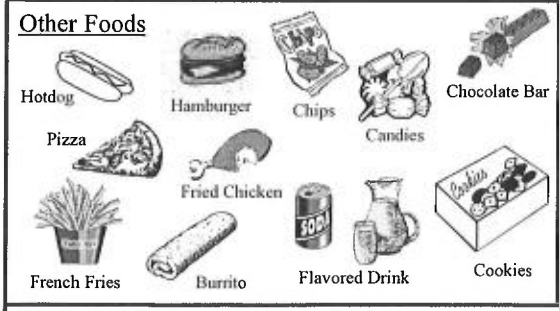
Milk Products/Calcium Rich Foods



Protein/Iron Rich Foods



Other Foods



Circle if baby/child uses:

Circle if your baby or child receives food from:

Food Stamps **School Lunch** **Head Start** **WIC**

Circle activities your baby or child does every day.

Drinks water?

Child's name:_____ **Record #:**_____

Age: ____ **yrs.** ____ **mos.** **Wt:** ____ **lbs.** **Ht:** ____ **in.** **Date:** ___/___/___

Adapted from the Orange and San Bernardino Counties CHDP Programs.

DHCS 4035 A (09/07)

Office Use Only
Feeding milestones to check/visit

Baby: Birth to 24 months

Yes / No

☐ ☐ Breast-fed 8–12 times/24 hours during early weeks of lactation OR every 3–4 hours/day for older infants?

☐ ☐ Formula-fed w/iron no less than 20 ounces/day? Correct dilution?

☐ ☐ No honey/Karo Syrup until 1 year?

☐ ☐ 4–6 months: Start on baby cereal with iron?

☐ ☐ 5–7 months: Start on pureed vegetables and fruits?

☐ ☐ 6–7 months: Drink from a cup?

☐ ☐ 6–8 months: Start on pureed or ground meat, i.e., poultry, beef, pork, fish, egg yolk, beans, tofu?

☐ ☐ 7–9 months: Eats finger foods and mashed/chopped foods, NO grapes, nuts, popcorn, hotdogs, hard candy?

☐ ☐ 1 year: Drinks regular milk no less than 16 ounces/day?

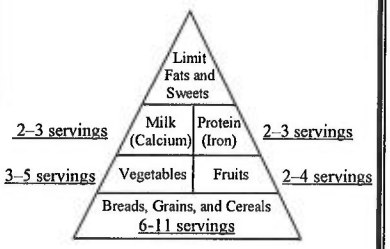
☐ ☐ 9–12 months: Feeds self, joins family meal and snack times?

☐ ☐ 12–24 months: Eats variety of foods: small portions, i.e., 1–2 Tbsp., ½ c juice, ½ slice of bread.

Child: 2 to 8 years

Yes / No

☐ ☐ Eats recommended variety and amounts of foods daily for age from the food guide pyramid?



Mealtime/Others:

Yes / No

☐ ☐ Set meal and snack times?

☐ ☐ Brush teeth by himself at 5 years?

☐ ☐ Good food supply?

☐ ☐ Takes vitamins, iron, or fluoride?

☐ ☐ Growing normally according to his/her growth patterns?

☐ ☐ Does child play with or eat dirt, plaster, clay, and paint chips?

☐ ☐ Any food intolerances or allergies?

_____

☐ ☐ Referral for identified nutrition problem? Where? _____

Activity:

☐ ☐ Actively plays everyday, i.e., running, biking, sports, 1 hour/day?

☐ ☐ TV viewing: 2 hours or less/day?

State of California—Health and Human Services Agency

Department of Health Care Services
Child Health and Disability Prevention (CHDP) Program

Con Quý Vị Ăn Những Gì?

Khoanh Tròn thực phẩm mà con quý vị ***ăn*** mỗi ngày hay ít nhất 3 lần một tuần:

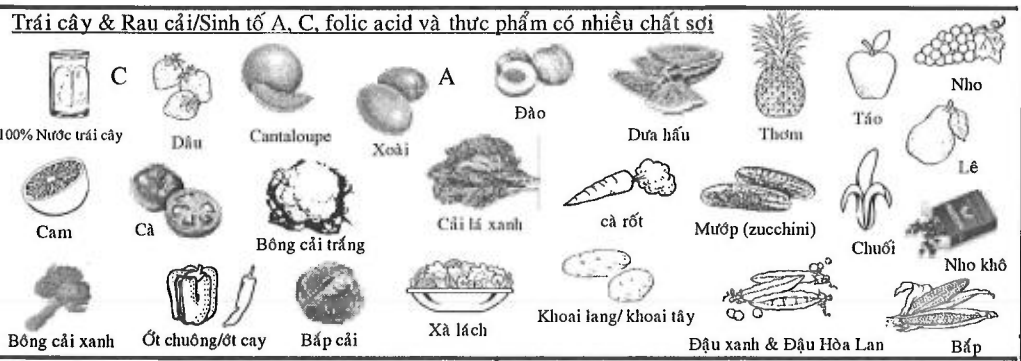
Thực phẩm em bé

Con quý vị có thích những món ăn này không?



Bánh, hột, ngũ cốc

Trái cây & Rau cải/Sinh tố A, C, folic acid và thực phẩm có nhiều chất sợi



Sản phẩm từ sữa/Thực phẩm có nhiều chất vôi

Chất đạm/Thực phẩm có nhiều chất sắt

Thực phẩm khác foods

Khoanh tròn nếu em bé/con quý vị dùng :

Khoanh tròn nếu em bé hay con quý vị nhận thực phẩm từ:

Phiếu thực phẩm | Cơm trưa tại trường | Head Start | WIC

Khoanh tròn các hoạt động mà con quý vị làm mỗi ngày

Uống nước?

Tên đứa trẻ: _____ Số hồ sơ:_____

Tuổi: _____ năm _____ tháng Cân nặng: _____ lbs. Cao: _____ in. Ngày: ____/____/____

LAC/DHS CMS–CHDP/CLPPP duyệt lại tháng 10/2001. Phối hợp từ Ban Sức Khỏe Công Cộng, Chương trình CHDP của quận Cam và San Bernardino.
Translated by Santa Clara County CHDP Program.

DHCS 4035 A (09/07) (Vietnamese)

Dành Riêng cho Văn Phòng
Ngày tháng cho ăn để kiểm/thăm viếng

Em bé: Sơ sinh đến 24 tháng

Có / Không

☐ ☐ Cho con bú sữa mẹ từ 8 - 12 lần/24 giờ trong thời kỳ cho con bú HAY mỗi 3-4 giờ/ngày cho em bé lớn hơn?

☐ ☐ Uống sữa hộp có chất sắt không ít hơn 20 oz/ngày? Pha sữa đúng cách?

☐ ☐ Không dùng mật ong/xi rô Karo cho đến khi được 1 tuổi?

☐ ☐ 4 - 6 tháng: Bắt đầu cho ăn ngũ cốc em bé có chất sắt?

☐ ☐ 5 - 7 tháng: Bắt đầu cho ăn rau cải và trái cây nguyên chất?

☐ ☐ 6 – 7 tháng: Uống bằng tách?

☐ ☐ 6 - 8 tháng: Bắt đầu ăn thịt nguyên chất hay xay, chẳng hạn như thịt gà, bò, heo, cá, tròng đỏ trứng, đậu, tàu hủ?

☐ ☐ 7 - 9 tháng: Ăn bốc tay & và thực phẩm tán nhuyễn, bầm, KHÔNG ăn nho, đậu, bắp rang, hotdogs, kẹo cứng?

☐ ☐ 1 năm: Uống sữa thường không ít hơn 16 oz/ngày?

☐ ☐ 9 - 12 tháng: Tự ăn, tham gia bữa cơm gia đình & lúc ăn vặt?

☐ ☐ 12 - 24 tháng: Ăn nhiều loại thực phẩm khác nhau: số lượng ít chẳng hạn như 1-2 muỗng cà phê, 1/2 tách nước trái cây, 1/2 miếng bánh mì.

Trẻ em: 2 đến 8 tuổi

Có / Không

☐ ☐ Dùng số lượng thực phẩm hàng ngày khác nhau đúng với chỉ dẫn theo tuổi từ hình tháp hướng dẫn thực phẩm?

Giờ ăn/Việc khác:

Có / Không

☐ ☐ Ấn định giờ ăn & giờ ăn vặt?

☐ ☐ Đến 5 tuổi tự đánh răng?

☐ ☐ Cung Cấp Đầy Đủ Thực Phẩm Tốt?

☐ ☐ Uống sinh tố, chất sắt, hay dùng floride chống sâu răng?

☐ ☐ Phát triển bình thường theo mô hình phát triển?

☐ ☐ Em có chơi hay ăn đất, thạch cao, đất sét và sơn tróc không?

☐ ☐ Có thực phẩm nào không thích nghi hay bị dị ứng không? _____

☐ ☐ Được giới thiệu để tìm hiểu về vấn đề dinh dưỡng? Nơi nào? _____

Hoạt Động:

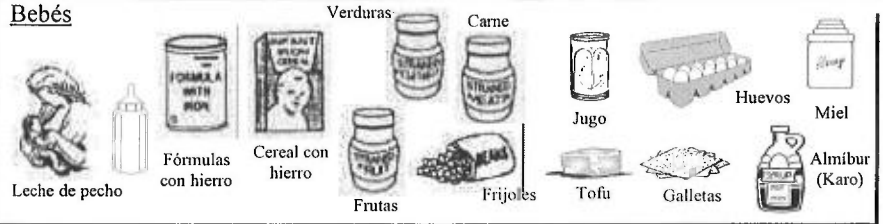
☐ ☐ Chơi đùa tích cực hàng ngày thí dụ như chạy, đạp xe đạp, thể thao, 1 giờ/ngày?

☐ ☐ Xem TV: 2 giờ hay ít hơn/ngày?

¿Qué Come Su Niño?

Ponga un circulo en las comidas que su niño ***come*** cada día o al menos 3 veces a la semana:

Bebés



Ponga un círculo en el dibujo que muestra como se siente su bebé o niño a la hora de comer:

Tortillas, Panes, Granos y Cereals

Frutas y Verduras (Ricas en Vitaminas A, C, Ácido Fólico y Fibra)

Alimentos Ricos en Calcio

Alimentos Ricos en Proteína y Hierro

Otras Comidas

Ponga un círculo si su bebé o niño usa:

Ponga un círculo si su bebé o niño recibe comida de:

Food Stamps **School Lunch** **Head Start** **WIC**

Ponga un círculo en las actividades que su bebé o niño hace diario:

Toma agua:

Child's name: _____ **Record #:** _____

Age: _____ **yrs.** _____ **mos.** **Wt:** _____ **lbs.** **Ht:** _____ **in.** **Date:** ___/___/___

Adapted from the Orange and San Bernardino Counties CHDP Programs.

DHCS 4035 A (Spanish) (08/07)

Office Use Only

Feeding milestones to check/visit

Baby: Birth to 24 months

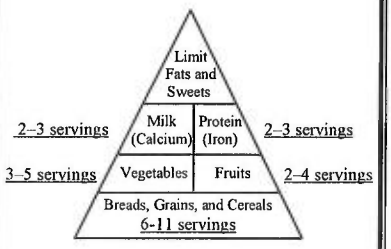
Yes / No

- ☐ ☐ Breast-fed 8–12 times/24 hours during early weeks of lactation OR every 3–4 hrs./day for older infants?
- ☐ ☐ Formula-fed w/iron no less than 20 ounce/day? Correct dilution?
- ☐ ☐ No honey/Karo Syrup until 1 year?
- ☐ ☐ 4–6 months: Start on baby cereal with iron?
- ☐ ☐ 5–7 months: Start on pureed vegetables and fruits?
- ☐ ☐ 6–7 months: Drink from a cup?
- ☐ ☐ 6–8 months: Start on pureed or ground meat, i.e., poultry, beef, pork, fish, egg yolk, beans, tofu?
- ☐ ☐ 7–9 months: Eats finger foods and mashed/chopped foods, NO grapes, nuts, popcorn, hotdogs, hard candy?
- ☐ ☐ 1 year: Drinks regular milk no less than 16 ounces/day?
- ☐ ☐ 9–12 months: Feeds self, joins family meal and snack times?
- ☐ ☐ 12–24 mos.: Eats variety of foods: small portions, i.e., 1–2 Tbsp., ½ c juice, ½ slice of bread.

Child: 2 to 8 years

Yes / No

- ☐ ☐ Eats recommended variety and amounts of foods daily for age from the food guide pyramid?



Mealtime/Others:

Yes / No

- ☐ ☐ Set meal and snack times?
- ☐ ☐ Brush teeth by himself at 5 years?
- ☐ ☐ Good food supply?
- ☐ ☐ Takes vitamins, iron, or fluoride?
- ☐ ☐ Growing normally according to his/her growth patterns?
- ☐ ☐ Does child play with or eat dirt, plaster, clay, and paint chips?
- ☐ ☐ Any food intolerances or allergies? _____
- ☐ ☐ Referral for identified nutrition problem? Where? _____

Activity:

- ☐ ☐ Actively plays everyday i.e., running, biking, sports, 1 hour/day?
- ☐ ☐ TV viewing: 2 hours or less/day?

What Does Your Child Eat?

Guidelines for Diet and Nutrition Screening for Children Ages Birth Through Eight Years

This tool helps to identify the child's risks for nutrition-related problems that may affect his/her growth and development.

Is the child being breastfed and/or formula fed with the recommended frequency and amounts?

Is the child started on solid foods at the recommended age and learning to eat and drink by himself as he/she gets older?

Is honey or Karo Syrup being given to the child during the first year?

The "Office Use" section identifies feeding milestones and key nutrition concerns to guide the staff to provide needed counseling and/or referral.

Are breads and cereals eaten daily for energy?

Are fruits and vegetables eaten daily, especially foods high in vitamin A, C, folic acid, and fiber? Are these foods offered for snack?

Are foods high in iron and protein eaten daily? Is child anemic or at risk for anemia?

Are dairy products eaten daily? If not, are other good sources of calcium eaten?

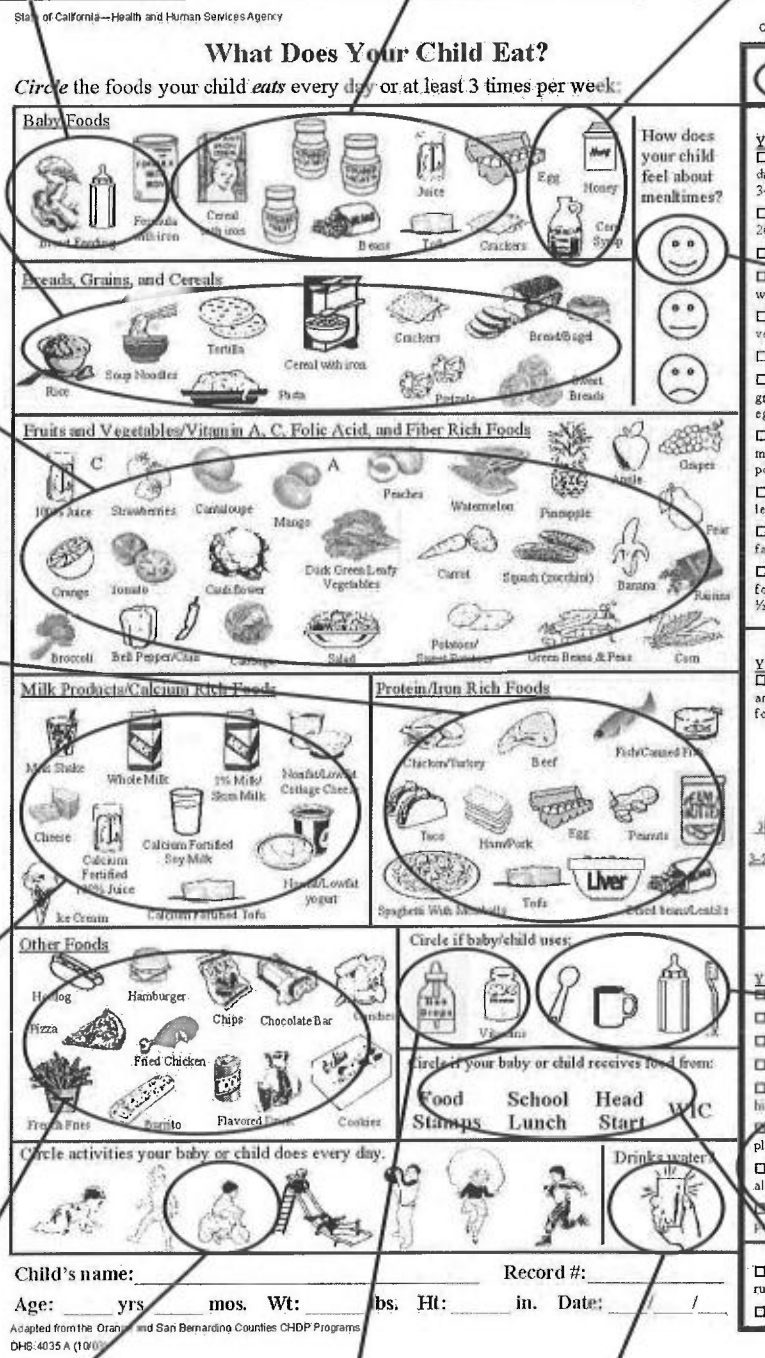
Are high fat/sugar foods eaten often?

Are mealtimes happy? Is the child eating regularly most of the time? Is the child at risk for eating disorders?

Is the child eating a variety of foods daily from the food guide pyramid? Are serving sizes enough for a young child such as: Cereal = ½–1 c, Fruit Juice = ½ c, Milk = 4 oz. and Meat = 1–2 oz.

Is the child at risk for baby bottle tooth decay and learning dental hygiene early?

Is the child at risk for lead poisoning or have food allergies or intolerances? Any nutrition referral done?



Is the child actively playing everyday?

Is the child taking iron, vitamins, and minerals?

Is water offered daily, especially after active play?

Is the child qualified to receive help from local food resources?

Adapted from the Orange and San Bernardino Counties CHDP Programs.

Youth Nutrition and Activity Assessment
(Ages 8-21)

Provide additional information on your food, activity and health habits.

Health professionals: Complete assessment in the shaded boxes below using all information provided.

Eating Habits:

Do you eat or drink:	Yes	No	Examples/Comments
breakfast?	☐	☐	_____
morning snack?	☐	☐	_____
lunch?	☐	☐	_____
afternoon snack?	☐	☐	_____
dinner?	☐	☐	_____
evening snack?	☐	☐	_____
milk?	☐	☐	_____
soda, coffee, tea?	☐	☐	_____
beer, wine or other alcohol?	☐	☐	_____

Eating Habits:

Yes	No	
☐	☐	Is the overall diet adequate? Does it include:
		☐ 3 meals/2 snacks
		☐ high iron foods
		☐ calcium foods
		☐ 5 or more fruits and vegetables
		☐ dequate fluids
☐	☐	Is hgb/hct within normal limits?
☐	☐	Has there ever been a lead test?_____
☐	☐	Counseling given (topics):_____
☐	☐	Further counseling needed (topics):_____
☐	☐	Referral made to:_____

Exercise/Physical Activity:

How many hours per day do you:
- watch TV? _____hours per day
- play video/computer games? _____hours per day
- surf the internet/chat rooms? _____hours per day

(Circle all that apply) Do you walk, run, bicycle, rollerblade or dance? Do you play basketball, softball, soccer, volleyball, other team sports?

Do you participate in physical education classes at school?
☐ Yes ☐ No

Other activities_____

How often are you physically active?
_____times per week _____minutes each time

Yes	No	
☐	☐	Limit use of TV/computer/video/internet (1-2 hours/day or less) Goals set?_____
☐	☐	Encourage activity (60 minutes/day or more) Goal set?_____
☐	☐	Referral made to:_____

Weight/Body Image:

Are you trying to:
☐ lose weight ☐ gain weight ☐ stay the same?

Do you eat less to control your weight? ☐ Yes ☐ No
Explain:_____

Have you ever made yourself vomit? ☐ Yes ☐ No
If yes, how often?_____When was the last time?_____

Do you ever "binge" eat? ☐ Yes ☐ No
If yes, how often? _____ When was the last time?_____

Are you currently using diet pills, laxatives, supplements, steroids, protein powders? ☐ Yes ☐ No

Other products used_____

BMI_____Date_____

- ☐ Acceptable Range BMI between 5th and 85th percentile
- ☐ At risk of overweight BMI for age > 85th percentile, < 95th percentile
- ☐ Overweight BMI for age > 95th percentile
- ☐ Underweight BMI for age < 5th percentile

Yes	No	
☐	☐	General signs of an eating disorder?
☐	☐	Understands healthy eating?
☐	☐	Counseling given? Topics:_____
☐	☐	Referral made to:_____

Completed by Name/Title:_____ **Date:**_____

Developed by the CHDP Nutrition Sub-Committee in cooperation with Department of Public Health, Human Services System, County of San Bernardino and Department of Public Health, Community Health Agency, County of Riverside 0306-224.ai MDS Rev 10/01

DHCS 4466 (09/07)

Last Name:	First Name	MRN#:

PLACE OF SCREENING: CIRCLE ONE: ANSI – 69 ISO – 61

AUDIOMETER: SCORING: Child responds at 25 dB:

DATE OF LAST CALIBRATION: AGE:

1st Screen RIGHT EAR	1000	2000	3000	4000	LEFT EAR	1000	2000	3000	4000
Date:									
2nd Screen RIGHT EAR Date:					LEFT EAR				
Vision Test Date:	Right Eye with Glasses 20 /		Left Eye with Glasses 20 /		Comments: ______ ______ Referred to: X ______ Signature & Title of Person Performing Test				
	Right Eye without Glasses 20 /		Left Eye without Glasses 20 /						

DATE OF LAST CALIBRATION: AGE:

1st Screen RIGHT EAR	1000	2000	3000	4000	LEFT EAR	1000	2000	3000	4000
Date:									
2nd Screen RIGHT EAR Date:					LEFT EAR				
Vision Test Date:	Right Eye with Glasses 20 /		Left Eye with Glasses 20 /		Comments: ______ ______ Referred to: X ______ Signature & Title of Person Performing Test				
	Right Eye without Glasses 20 /		Left Eye without Glasses 20 /						

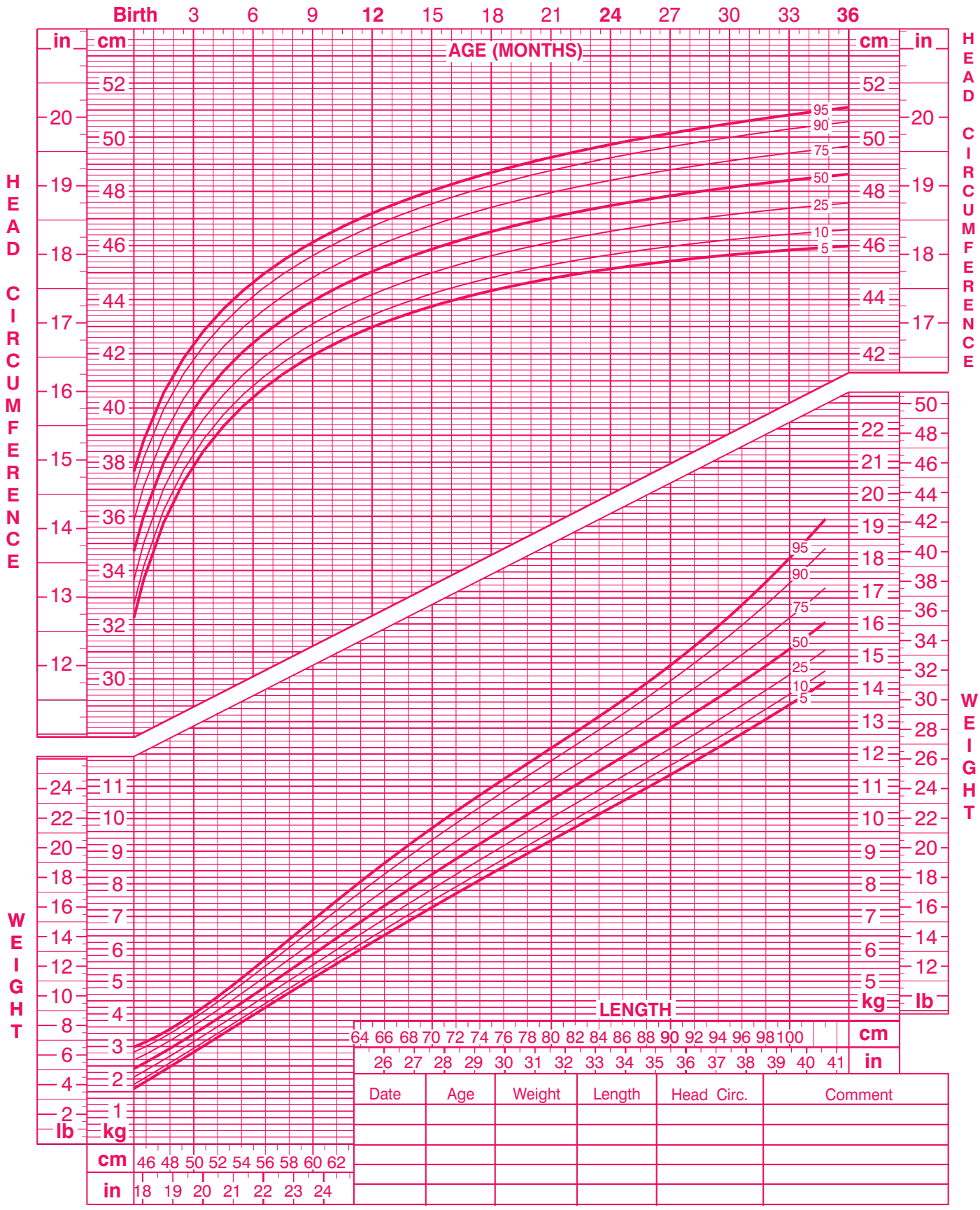
DATE OF LAST CALIBRATION: AGE:

1st Screen RIGHT EAR	1000	2000	3000	4000	LEFT EAR	1000	2000	3000	4000
Date:									
2nd Screen RIGHT EAR Date:					LEFT EAR				
Vision Test Date:	Right Eye with Glasses 20 /		Left Eye with Glasses 20 /		Comments: ______ ______ Referred to: X ______ Signature & Title of Person Performing Test				
	Right Eye without Glasses 20 /		Left Eye without Glasses 20 /						

Birth to 36 months: Girls
Head circumference-for-age and Weight-for-length percentiles

NAME _____

RECORD # _____



Published May 30, 2000 (modified 10/16/00).

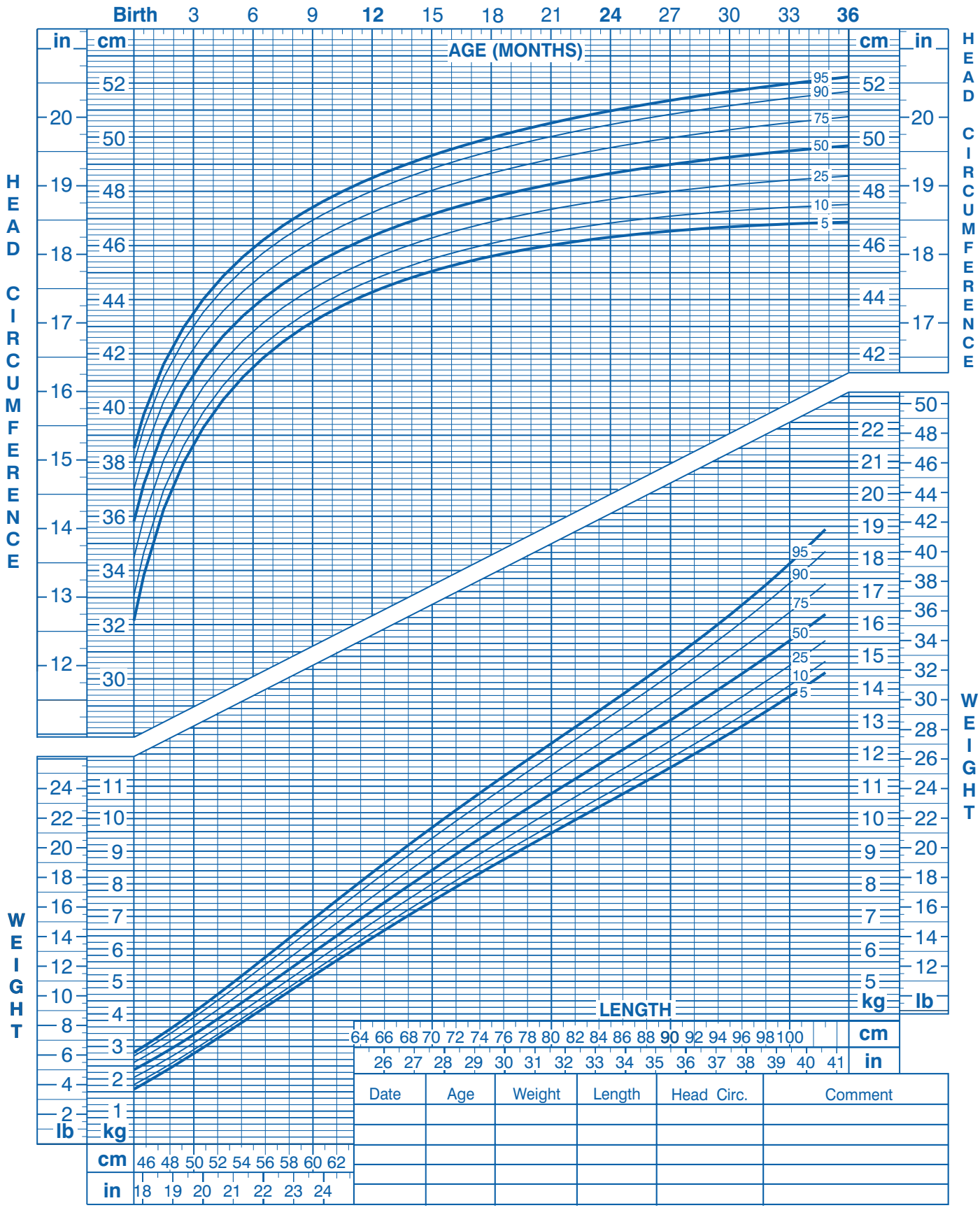
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

SAFER • HEALTHIER • PEOPLE™

Birth to 36 months: Boys
Head circumference-for-age and Weight-for-length percentiles

NAME _____

RECORD # _____



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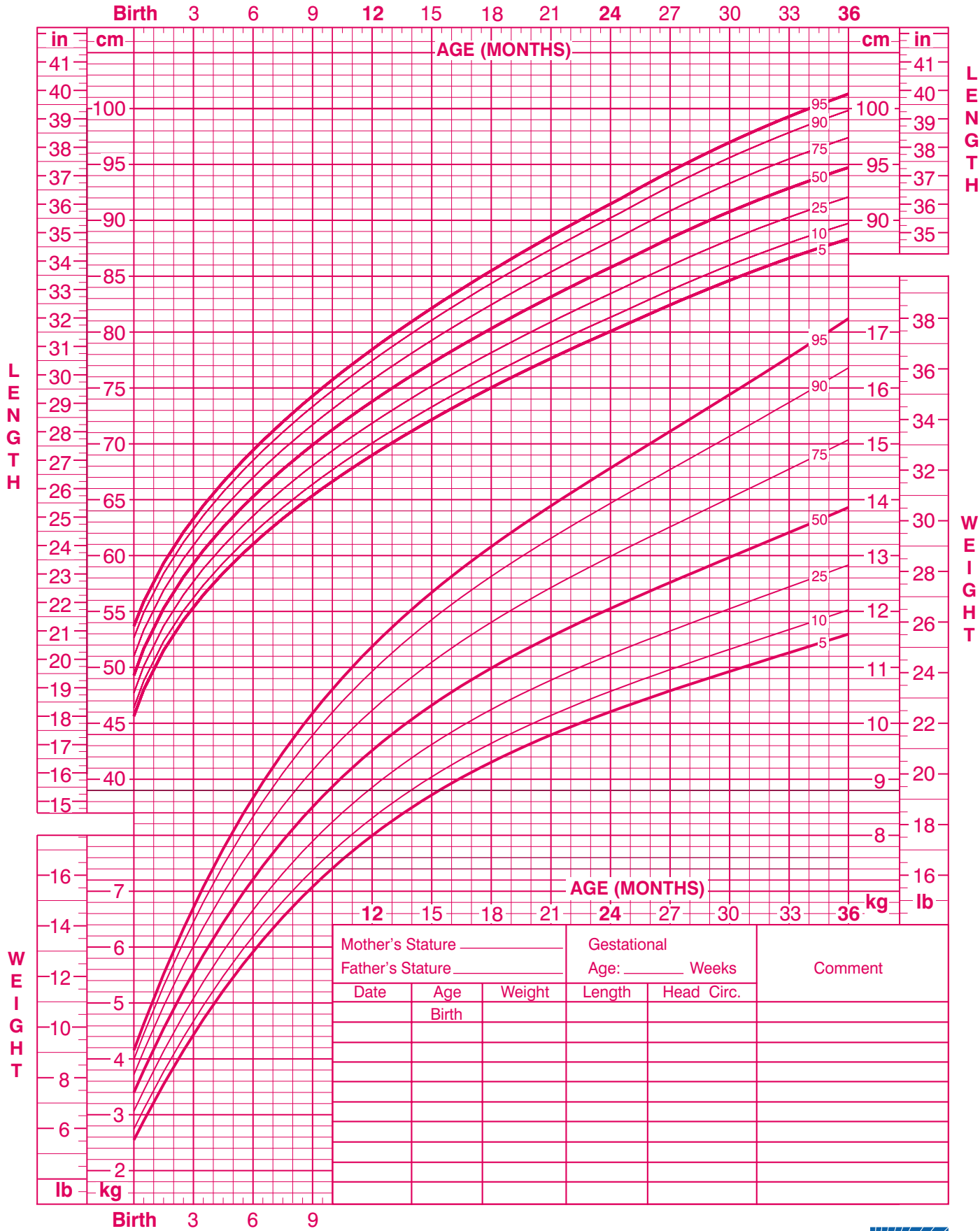
http://www.cdc.gov/growthcharts

SAFER • HEALTHIER • PEOPLE™

Birth to 36 months: Girls
Length-for-age and Weight-for-age percentiles

NAME _____

RECORD # _____



Published May 30, 2000 (modified 4/20/01).

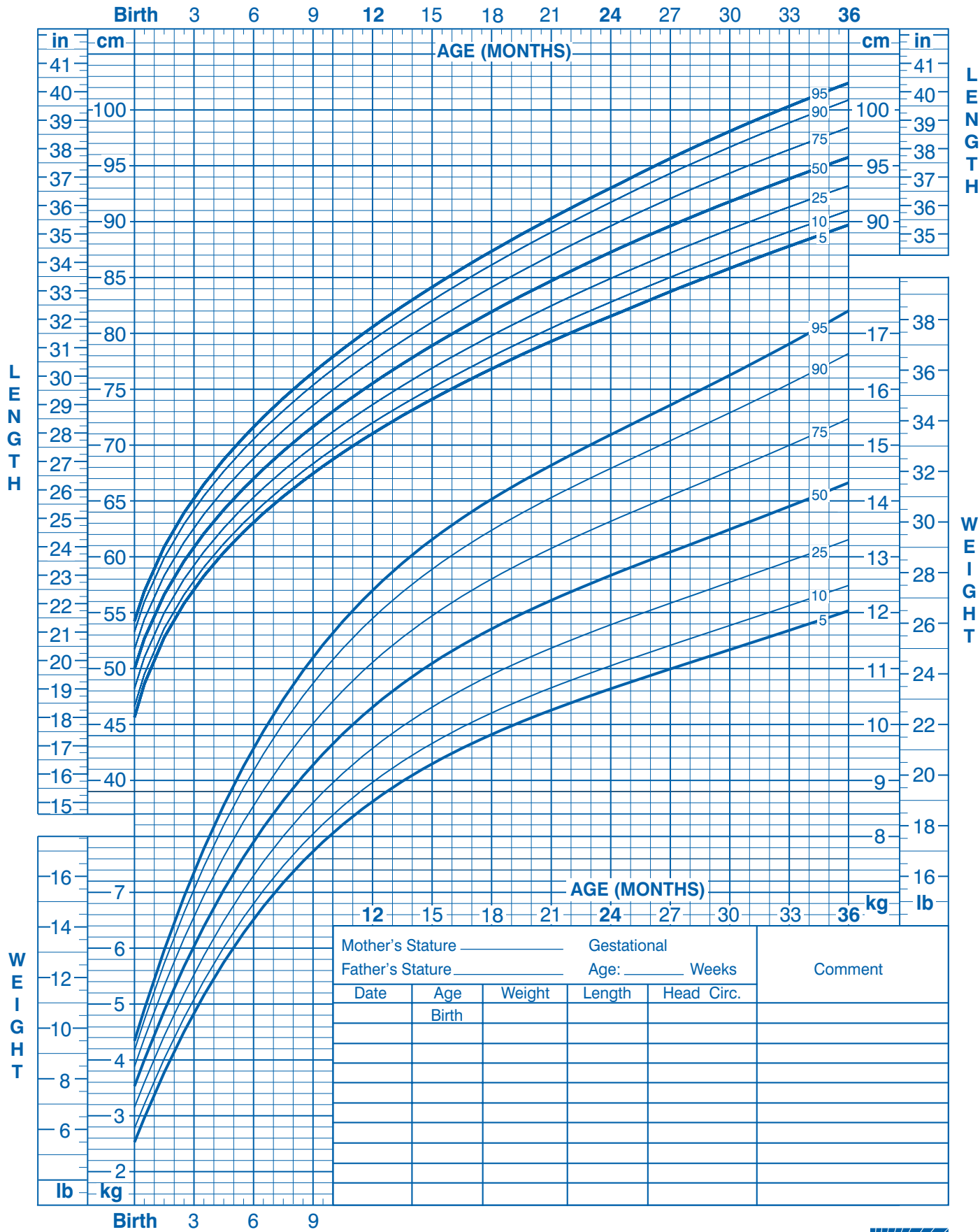
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

CDC
SAFER • HEALTHIER • PEOPLE™

Birth to 36 months: Boys
Length-for-age and Weight-for-age percentiles

NAME _____

RECORD # _____



Published May 30, 2000 (modified 4/20/01).

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http://www.cdc.gov/growthcharts

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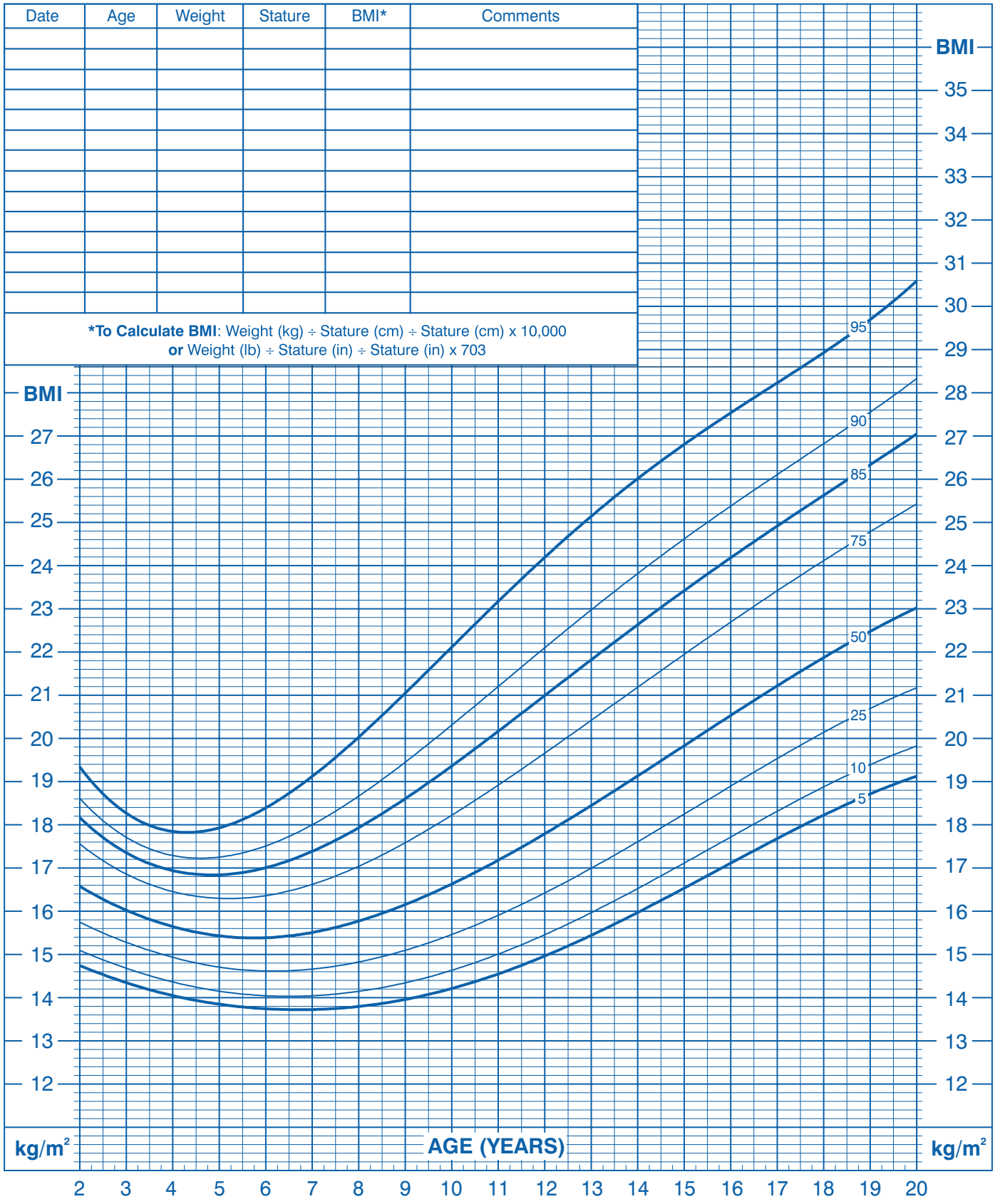
2 to 20 years: Boys
Body mass index-for-age percentiles

NAME _____

RECORD # _____

Date	Age	Weight	Stature	BMI*	Comments

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



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CDC
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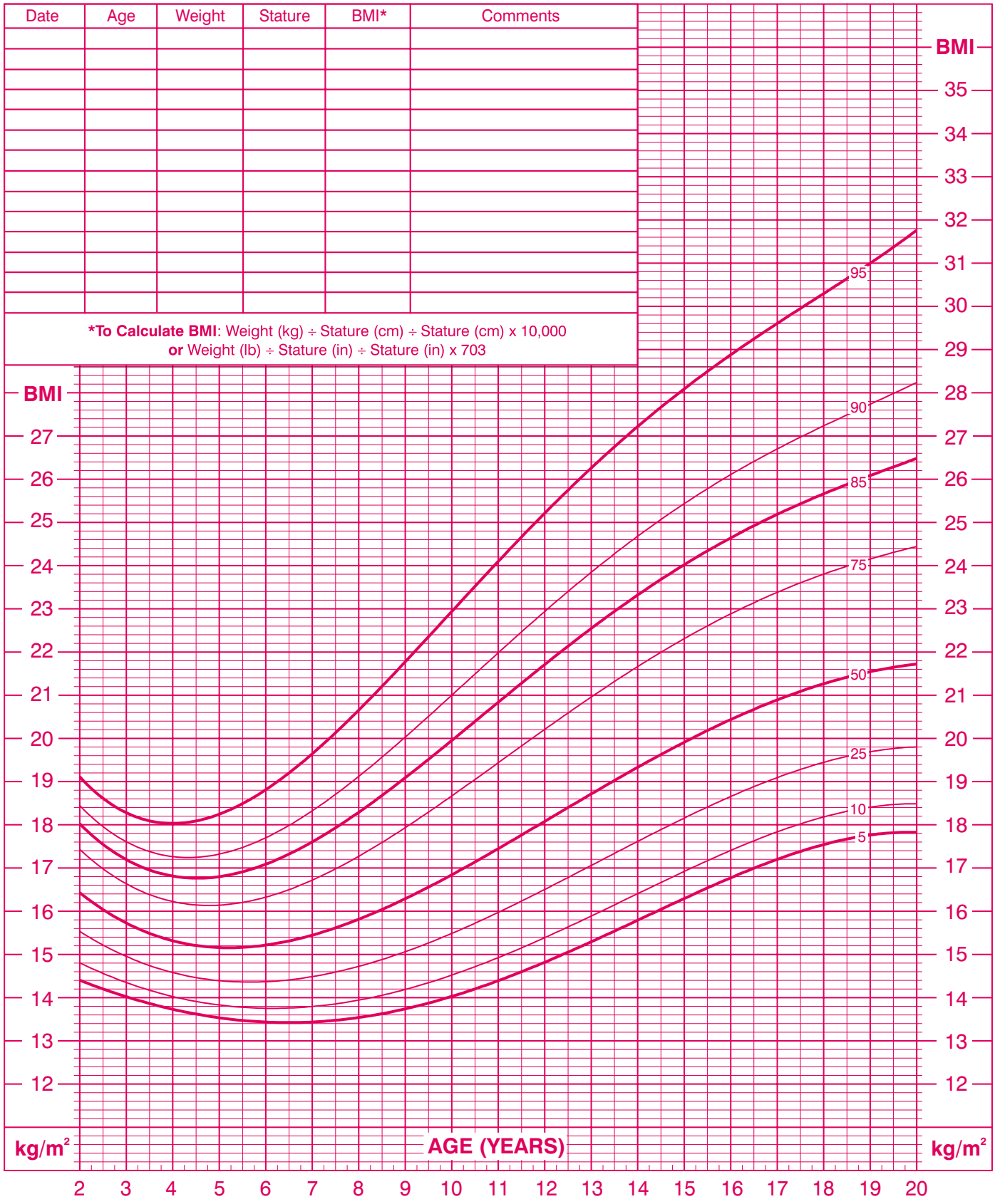
2 to 20 years: Girls
Body mass index-for-age percentiles

NAME _____

RECORD # _____

Date	Age	Weight	Stature	BMI*	Comments

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 10/16/00).
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http://www.cdc.gov/growthcharts

CDC
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Consent to Treatment of Minor

If the patient is a minor, or in any way incapacitated to sign for him/her self, this from is to be completed for each minor and filed in minor's chart.

TO: _____, its doctors, nurses, and members of its staff.

RE: _____, a minor.

DATE OF BIRTH: _____ ID NUMBER: _____

(I), (We), the undersigned, parent(s) or legal guardians (s) of

_____

A minor, authorize_____, to whom the minor has been entrusted, to act on my (our) behalf to consent to an X-Ray examination , anesthetic, medical or surgical diagnosis or treatment and care which is deemed advisable by, and is so be rendered under the general or special supervision of, any duly licensed physician or to consent to an X-ray examination ,anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to said minor by a dentist duly licensed.

Additionally, in accordance with California Health and Safety Code, Section 1283, (I) (We) authorize _____, parties rendering care on its behalf

To release the minor to the Physical custody of _____, upon Completion of the diagnosis, treatment of care.

This authorization shall remain effective until _____, unless sooner
Date/Year

Revoked in writing and delivered to _____.

Date: _____ _____
Parent or legal Guardian

Date: _____ _____ _____
Position Witness

GENERAL CONSENT

I, _____, authorize and direct _____, to Provide those diagnostic, preventative and therapeutic services which are deemed necessary for my health care.

_____ _____ _____

Date | Patient, parent, or legal Guardian | Witness Signature

If the patient is a minor, or in any way incapacitated to sign for him/her self, this from is to be completed for each minor and filed in minor's chart.

TO: _____, its doctors, nurses, and members of its staff.

RE: _____, a minor.

DATE OF BIRTH: _____ ID NUMBER: _____

(I), (We), the undersigned, parent(s) or legal guardians (s) of _____

A minor, authorize_____, to whom the minor has been entrusted, to act on my (our) behalf to consent to an X-Ray examination , anesthetic, medical or surgical diagnosis or treatment and care which is deemed advisable by, and is so be rendered under the general or special supervision of, any duly licensed physician or to consent to an X-ray examination ,anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to said minor by a dentist duly licensed.

Additionally, in accordance with California Health and Safety Code, Section 1283, (I) (We) authorize _____, parties rendering care on its behalf

To release the minor to the Physical custody of _____, upon Completion of the diagnosis, treatment of care.

This authorization shall remain effective until _____, unless sooner

Date/Year

Revoked in writing and delivered to _____.

Date: _____ _____

Parent or legal Guardian

Date: _____ _____ _____

Position | Witness

Consentimiento General

Yo, _____, autorizo y ordeno a _____,
Para que provea esos servicios diagnosticos, preventivos y terapeuticos que crea necesarios para mi cuidado de salud.

_____ _____ _____
Fecha Paciente,Padre o Tutor Firma de Testigo

CONCENTIMIENTO PARA EL TRATAMIENTO DE UN/A MENOR DE EDAD

Si el/la paciente es menor de edad, o de cualquier manera esta incapacitado/a para firmar por si mismo/a, este formulario debe ser llenado por cada menor y guardado en el archivo del menor.

A: _____, sus medicos, enfermeros/as y miembors de su personal.

Respecto a: _____, un /a menor de edad.

FECHA DE NACIMIENTO: _____ NUMERO DE ID: _____
(Yo), (Nosotros), el/los abajo firmando, padres(s) o tutor (es) de _____
Un/a menor, autorizo (amos) a _____, a quien el/la menor ha sido Encomendado/a, para actuar en mi (nuestro) nombre para dar permiso a una examinacion de rayos-x, anestecia, diagnosis medica o quirurgica o tratamineto y cuidado que se crea recomendable , y deben ser rendidas bajo supervison general o especial de, cualquier medico debidamento licensiado o dar consentimiento a una examinacion de rayos-X, anstesia, diagnosis dental o quirugica o tratamiento y cuidado de hospital para ser dada a dicho menor de edad por un dentista debidamente licensiado.

A demas, de acuerdo con el codigo de seguridad y Salud de Estado de California Secion 1283, (California Health and Safety Code, Section 1283) , (Yo), (Nosotros) autorizo (amos) a _____, o grupos rindiendo cuidado por su parte dar la custodia fisica del menor a _____, al completer el diagnosis, tratamiento para su cuidado.

Esta autorizacion permanecera en efecto hasta _____, a menos que sea
Fecha/Ano
Revocada ates de la fecha indicada en escrito y entregada a _____,

Fecha: _____ _____
Padre o Tutor

Fecha: _____ _____ _____
Titulo Testigo

PROBLEM FORM

NAME: _____DATE OF BIRTH _____ MRN _____

LANGUAGE PREFERENCE	__Arabic __Armenian __Cambodian __Cantonese __Chinese __English __Farsi __ Hmong __Korean __Mandarin __Russian __Spanish __Tagalog __Vietnamese Other _____ Other _____ Other_____
HEARING IMPAIRMENT ___ YES ___ NO	
Advance Directive Education : ___Yes ___Refused Date: Signature:	
ALLERGIES :	

#	Start Date	Problem or Significant Condition	Date Resolved	Medications	Dose	Frequency	Start Date	Stop Date
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
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31								
32								
33								
34								
35								
36								

PROBLEM FORM

NAME: _____ DATE OF BIRTH: _____ MRN_____

ALLERGIES:								
#	START DATE	PROBLEM OR SIGNIFICANT CONDITION	DATE RESOLVED	MEDICATIONS	DOSE	FREQUENCY	START DATE	STOP DATE
1								
2								
3								
4								
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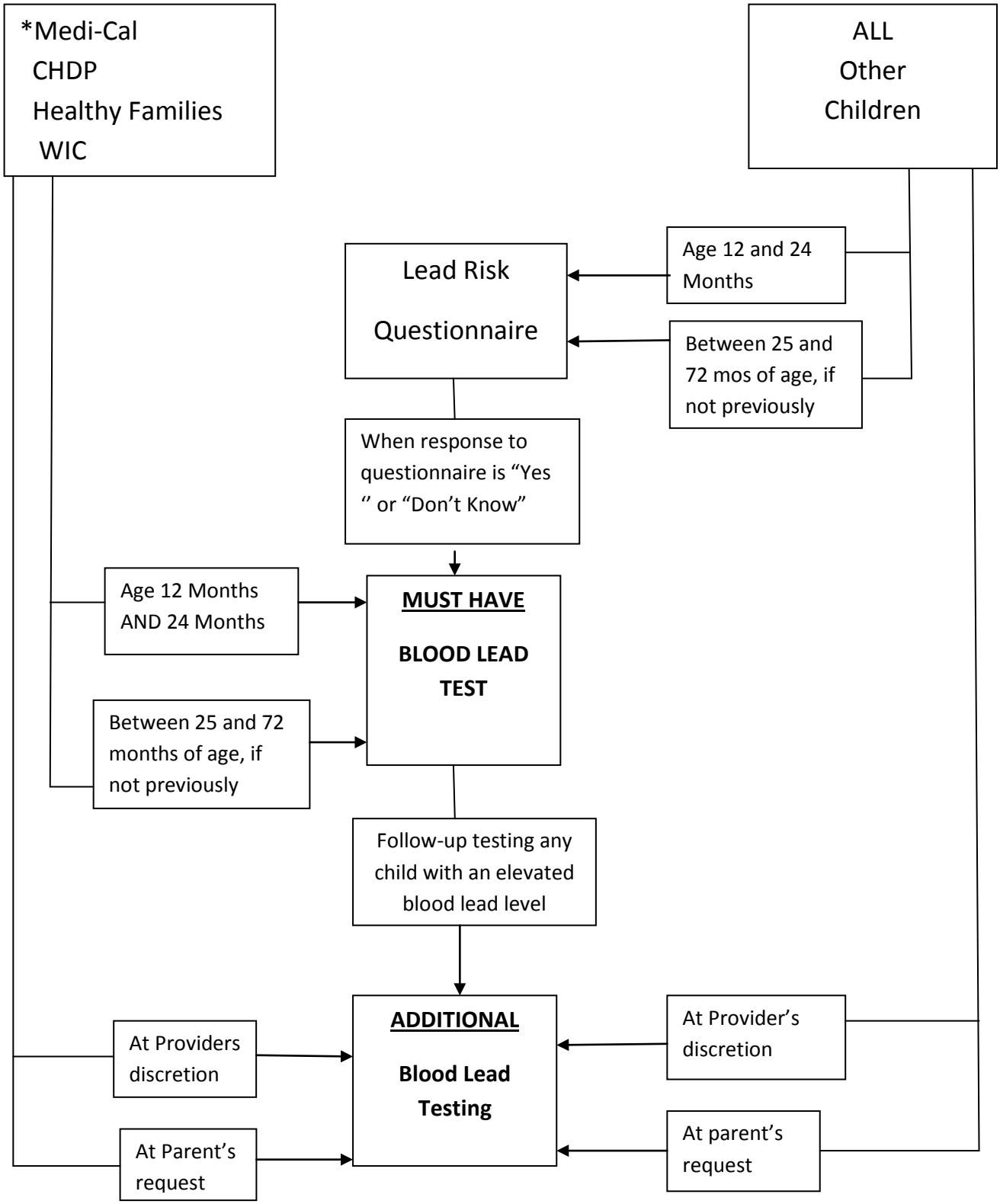
*Medi-Cal
CHDP
Healthy Families
WIC
ALL
Other
Children
Lead Risk
Questionnaire
Age 12 and 24 Months
Between 25 and 72 mos of age, if not previously
When response to questionnaire is "Yes '' or "Don't Know"
Age 12 Months AND 24 Months
MUST HAVE
BLOOD LEAD TEST
Between 25 and 72 months of age, if not previously
Follow-up testing any child with an elevated blood lead level
ADDITIONAL
Blood Lead Testing
At Providers discretion
At Parent's request
At Provider's discretion
At parent's request

California Tuberculosis Risk Assessment

- Use this tool to identify asymptomatic **adults** for latent TB infection (LTBI) testing.
- Re-testing should only be done in persons who previously tested negative, and have new risk factors since the last assessment.
- For TB symptoms or abnormal chest x-ray consistent with active TB disease → STOP → Evaluate for active TB disease

Evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.

Check appropriate risk factor boxes below.
LTBI testing is recommended if any of the 3 boxes below are checked.
If LTBI test result is positive and active TB disease is ruled out, LTBI treatment is recommended.

☐ **Foreign-born** person from a country with an elevated TB rate

- Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries.
- If resources require prioritization within this group, **prioritize** patients with at least one medical risk for progression (see Fact Sheet for list)
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for foreign-born persons

☐ **Immunosuppression,** current or planned

HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication

☐ **Close contact** to someone with infectious TB disease at any time

See the **California Tuberculosis Risk Assessment Fact Sheet** for more information about using this tool.

Provider: _____

Assessment Date: _____

Patient Name: _____

Date of Birth: _____

(Place sticker here if applicable)

Name: _____ Medical Record #: _____

Age: _____ DOB: _____ Date: _____

Please answer the following questions by checking the appropriate box /
Conteste por favor a las preguntas siguientes y conteste con la respuesta apropiada:

1.	**Have you or anyone you see regularly been diagnosed or suspected of being sick with active TB disease?** ¿Ha sido usted o cualquier persona que usted ve regularmente diagnosticado o sospechado de ser enfermo con la enfermedad activa de la tuberculosis?	☐ Yes/Si ☐ No
2.	**Do you or have you had symptoms of TB, such as cough, chest congestion, fever, night sweats, and/or weight loss?** ¿Usted tiene o ha tenido síntomas de la tuberculosis, tales como tos, congestión del pecho, fiebre, sudor en las noches, y/o pérdida de peso?	☐ Yes/Si ☐ No
3.	**Do you have family members or frequent visitors who were born in high TB prevalent countries (most countries from Asia, Africa, Latin America, parts of Eastern Europe)?** ¿Usted tiene miembros de la familia o visitantes que nacieron en los países frecuentes de la alta tuberculosis (la mayoría de los países de Asia, de África, de América latina, partes de Europa Oriental)?	☐ Yes/Si ☐ No
4.	**Were you born in, or travel to high TB prevalence countries (most countries from Asia, Africa, Latin America, parts of Eastern Europe)?** ¿Usted nació dentro, o viajo a los países altos del predominio de la tuberculosis (la mayoría de lospaíses de Asia, de África, de América latina, partes de Europa Oriental)?	☐ Yes/Si ☐ No
5.	**Do you live in out of home placements (such as board & care or residential facilities)?** ¿Usted vive dentro de las colocaciones caseras (tales como casa de huéspedes o instalaciones residenciales)?	☐ Yes/Si ☐ No
6.	**Do you have HIV infection, or other immunosuppressive condition?** ¿Usted tiene la infección del VIH, u otra condición immunosuppresiva?	☐ Yes/Si ☐ No
7.	**Do you live with someone with HIV?** ¿Usted vive con alguien con el VIH?	☐ Yes/Si ☐ No
8.	**Do you live, or frequently visit, with persons who have been incarcerated in the last 5 years?** ¿Usted vivió, o visita con frecuencia, con personas que fueron encarcelados en los ultimos 5 años?	☐ Yes/Si ☐ No
9.	**Do you live among or been frequently around individuals who are homeless, migrant workers, users of street drugs, or residents in nursing homes?** ¿Usted vive entre o frecuenta los alrededores de individuos sin hogar, trabajadores emigrantes, usuarios de las drogas de la calle, o residentes en clínicas de reposo?	☐ Yes/Si ☐ No
10.	**Do you consume alcoholic beverages?** ¿Usted consume bebidas alcohólicas?	☐ Yes/Si ☐ No

TO BE COMPLETED BY THE MEDICAL STAFF / SER COMPLETADO POR EL PERSONAL MÉDICO:

Administer the Mantoux TB skin test to all adults who have any of the above risk factors (indicated by a Yes response) UNLESS:

1. The patient has a previously documented positive Mantoux TB skin test, or
2. The patient has had a TB skin test within the last 12 months, or
3. The patient has been vaccinated with BCG within the last 12 months.

Reason for TB skin test if other than periodic evaluation:
☐ work ☐ school ☐ TB contact ☐ prenatal ☐ other, specify: _____

Note: Only trained licensed personnel may read/interpret the skin test.

Nurse/Provider Signature: _____ Date: _____

Adult TB Exposure Risk Assessment

Name of Child: _____ Medical Record #: _____

Age: _____ DOB: _____ Date: _____

Please answer the following questions by checking the appropriate box:
Conteste por favor a las preguntas siguientes y conteste con la respuesta apropiada:

1.	**Has a family member or anyone the child sees regularly been diagnosed or suspected of being sick with active TB disease?** ¿Hay un miembro de la familia o alguien que el niño(a) ve regularmente que a sido diagnosticado o se sospecha de ser enfermo con la enfermedad activa de la tuberculosis?	☐ Yes/Si ☐ No
2.	**Has the child had symptoms of TB, such as cough, chest congestion, fever, night sweats, and/or weight loss?** ¿Ha tenido síntomas el niño(a) de la tuberculosis, tales como tos, congestión del pecho, fiebre, sudor en las noches, y/o pérdida de peso?	☐ Yes/Si ☐ No
3.	**Was the child born in, or travel to high TB prevalence countries (most countries from Asia, Africa, Latin America, parts of Eastern Europe)?** ¿El niño(a) nacido en o ha viajado en los países frecuentes de la alta tuberculosis (la mayoría de los países de Asia, de África, de América latina, partes de Europa Oriental)?	☐ Yes/Si ☐ No
4.	**Does the child live in out of home placements (such as board & care or Residential facilities)?** ¿El niño(a) vive en colocaciones caseras (tales como casa de huéspedes o instalaciones residenciales)?	☐ Yes/Si ☐ No
5.	**Does the child have HIV infection, or other immunosuppressive condition?** ¿El niño(a) tiene la infección de VIH, o otra condición immunosuppresiva?	☐ Yes/Si ☐ No
6.	**Does the child live with someone with HIV?** ¿El niño(a) vive con alguien con el VIH?	☐ Yes/Si ☐ No
7.	**Does the child live, or frequently visit, with persons who have been incarcerated in the last 5 years?** ¿El niño(a) vive, o visita con frecuencia, con personas que fueron encarcelados en los últimos 5 años?	☐ Yes/Si ☐ No
8.	**Does the child have family members or frequent visitors who were born in high TB prevalence countries (most countries from Asia, Africa, Latin America, parts of Eastern Europe)?** ¿Tiene el niño(a) miembros de familia o invitados de frecuencias que nacieron en países de predominio altos TB (la mayor parte de países de Asia, África, América Latina, partes de Europa de Este)?	☐ Yes/Si ☐ No
9.	**Has the child lived among or been frequently around individuals who are homeless, migrant workers, users of street drugs, or residents in nursing homes?** ¿El niño(a) vive entre o frecuenta los alrededores de individuos sin hogar, trabajadores emigrantes, usuarios de las drogas de la calle, o residentes en clínicas de reposo?	☐ Yes/Si ☐ No

TO BE COMPLETED BY THE MEDICAL STAFF / SER COMPLETADO POR EL PERSONAL MÉDICO:

Administer the Mantoux TB skin test to all children who have any of the above risk factors (indicated by a Yes response), UNLESS:

1. The child has a previously documented positive Mantoux TB skin test, or
2. The child has had a TB skin test within the last 12 months, or
3. The patient has been vaccinated with BCG within the last 12 months.

Reason for TB skin test if other than periodic evaluation:
☐ work ☐ school ☐ TB contact ☐ prenatal ☐ other, specify: _____

NOTE: Only trained licensed personnel, **not parents or guardians** may read/interpret the skin test.

Nurse/Provider Signature: _____ Date: _____

Pediatric TB Exposure Risk Assessment

LOS ANGELES COUNTY

Do you know that your child still has dental coverage?

Your child is moving from the **Healthy Families Program** into Medi-Cal and now has dental coverage through the Medi-Cal Dental program!

What is the Medi-Cal Dental program?

The Medi-Cal Dental program is the part of the Medi-Cal program that will provide dental benefits for your children who have been covered by the Healthy Families Program.

Who is covered?

All Healthy Families Program children up to their 19th birthday who are moving to Medi-Cal are covered. After their 19th birthday they may be eligible for other Medi-Cal programs.

For families living in Los Angeles County:

If your child is enrolled in Access Dental, Health Net of CA, SafeGuard Dental or Western Dental through the Healthy Families Program they will stay in the same dental plan in the Medi-Cal Dental Program. If your child is not in one of these dental plans, they will automatically be enrolled into Denti-Cal (www.denti-cal.ca.gov). Either way you can choose to change your child's dental plan or enroll them into Denti-Cal by contacting Health Care Options at 1-800-430-4263. Please see below for the dental plans available in Los Angeles County.

What services are covered?

The dental benefits available to children in the Medi-Cal Dental program are very similar to those in the Healthy Families program and include:

- Exams and preventive services including cleanings, fluoride treatments and sealants
- Fillings
- Root canals
- Crowns
- Relief of pain and infection

Los Angeles County Dental Plan Choices:	
Access Dental	(888) 414-4110
Denti-Cal	(800) 322-6384
Health Net of CA	(800) 977-7307
LIBERTY Dental	(888) 703-6999
SafeGuard Dental	(800) 880-3080
Western Dental	(800) 805-8000

Please check with your child's Dental Managed Care plan or Denti-Cal about what benefits are available.

How does my child get the dental services they need? (Checklist)

Dental Managed Care Plans

- ☐ Contact your child's Dental Managed Care plan to:
  - ☐ Find out what services your child can receive
  - ☐ Find a dentist
- ☐ Contact dentist to make appointment
- ☐ Go to dental appointment (Don't forget to take your child's dental plan identification card!)

Denti-Cal

- ☐ Contact Denti-Cal (1-800-322-6384) to:
  - ☐ Find out what services your child can receive
  - ☐ Find a dentist
- ☐ Contact dentist to make appointment
- ☐ Go to dental appointment (Don't forget to take your child's Beneficiary Identification Card!)