Clinic Policies for Primary Care Provider Settings

Instructions:

All Medi-Cal Managed Care (Medi-Cal) provider sites are required to establish safety, member rights and general policies and procedures for their practice. Please review all sample policies and procedures below and customize any or all of the policies and their respective attachments you wish to adopt based on your clinic's practice and processes. Please complete the *Approval date*, *Approved by*, *Effective Date*, and *Revision date* for each of the adopted policies. All providers and staff shall receive trainings/in-services on all clinic policies and procedures. Annual trainings/in-services are required for *Blood-Borne Pathogens Exposure Control*, *Biohazardous Waste Management* and *Infection Control/Standard/Universal Precautions*. All clinic policies and evidence of training shall be kept on site or made available upon request.

IMPORTANT: When printing these policies, please print all applicable ATTACHMENTS as well.

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Safety and Member Rights Core Policies:

General Policies:

SECTION	Approval date:	
Infection Control	Approved by:	
POLICY AND PROCEDURE	Effective date:	
Blood-Borne Pathogens and Biohazardous Waste Management	Revision 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); HandS Code, §§117600-118360 (CA Medical Waste Management Act, 1997); 29 CFR §1910, 1030.

PROCEDURE:

I. Blood and Other Potential 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 blood borne 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,

- Water repelling gloves
- Clothing barrier (e.g., gown, sheets)
- Face/eye protection (e.g., goggles, face shield)
- 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.

D. The storage of PPE should be adequate to protect the PPE from contamination, loss, damage, water or sunlight. Proper storage often requires a dry and clean place that is not subject to temperature extremes.

III. 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 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. Needle-Stick 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. Needleless systems, sharps with engineered sharps injury protection (ESIP), and non-needle sharps are used unless exemptions have been approved by Cal/OSHA (8CCR, §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 three-quarters (¾) full. Supply of containers on hand is adequate to ensure routine change-out when filled.

V. 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.

VI. Contaminated Laundry

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"** and/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:

- 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
- Medical wastes, e.g., liquid/semi-liquid blood or OPIM, items caked with dry blood or OPIM and capable or releasing materials during handling, and contaminated sharps (Health and Safety Code, Chapter 6.1, CA Medical Waste Management Act).

VIII. Medical Waste Disposal

The method of medical waste disposal is as follows (check the method that applies):

☐ Medical waste are hauled to a permitted offsite medical waste treatment facility, to a transfer station, or to another registered generator for consolidation.

A limited-quantity exemption is not required for Small Quantity Generator (SQG - up to 35.2 pounds). For Large Quantity Generator (LQG - more than 35.2 pounds), hauling is done by a registered hazardous waste transporter or by a person with an approved limited-quantity hauling exemption granted by the CA DHS 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 LQG transporter carries the exemption form in the transporting vehicle. For both SQG and LQG, 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 LQG and 2 years for SQG.

☐ The medical building or hospital collects the medical waste from the clinic suite to a central accumulation area in the medical/hospital building where their contracted registered hauler picks up and hauls the waste for disposal.

☐ Other: _____
_____
_____

NOTE: Contaminated waste including materials soiled with blood or other body fluids/secretions that do not have the potential to be transmitted and infect others (e.g., dirty diapers, old bandages, etc.) are not within the scope of regulated waste. 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.

RESOURCES: OSHA Fact Sheet - Protecting Yourself When Handling Contaminated Sharps
Sharps Injury Log (Sample)

ATTACHMENTS: Blood-Borne Pathogen Exposure Control Plan (sample)
Medical Waste Tracking Log (sample)

SECTION	Approval date:	
Personnel	Approved by:	
POLICY AND PROCEDURE	**Effective date:**	
Child Abuse Reporting	**Revision date:**	

POLICY:

Any health care practitioner who has knowledge of or observes a child who, in a professional capacity or within the scope of his or her employment, is a suspected victim of child abuse or neglect, shall report the suspected incident of abuse or neglect to a "child protective services" agency.

PROCEDURE:

I. REPORTING

A. A report shall be made to child protective services (hereafter "CPS") agency. A child protective services agency is any county or probation department or a police or Sheriff's department (P.C. 11165.9, 11166[a]).

B. The initial report shall be made immediately (or as soon as possible, without delay) to the CPS agency by phone.

C. A written report shall be forwarded to the CPS agency within 36 hours of receiving the information regarding the incident.

D. Written reports shall be submitted on a Department of Justice form, Form SS 8572 (DOJ SS 8572), which can be requested from your local CPS agency.

E. A single report may be submitted for two or more persons with knowledge of or who suspect child abuse or neglect.

F. The following information should be included in the report:

a) Name of reporter
b) Name and present location of the child
c) Nature and extent of the injury as well as any evidence of prior abuse which may exist
d) Any other information, including what led you to suspect the child abuse – if requested by the CPS agency (P.C. § 11167 [a])

G. 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 due to a health care professional's failure to report.

II. INDICATORS OF ABUSE

A. Physical Abuse

Physical Indicators of Physical Abuse

- Fractures, lacerations, bruises that cannot be explained, or explanations that are improbable given the extent of the injury
- Burns (cigarette, rope, scalding water, iron, radiator)
- Infected burns, indicating a 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, fractures in various states of healing
- Pattern of bruising (e.g., parallel or circular bruises) or bruises in different stages of discoloration, indicating repeated trauma over time

Behavioral Indications of Physical Abuse

- Hostile, aggressive, verbally abusive towards others
- Fearful or withdrawn behavior
- Self-destructive (self-mutilates, bangs heads, etc.)
- Destructive (breaks windows, sets fires, etc.)
- Out-of-control behavior (seems angry, panics, is 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

Physical Indicators 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)

Behavioral indicators of Sexual Abuse

- Sexualized behavior (has precocious knowledge of explicit sexual behavior and engages self or others in 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

Behavioral indicators of Sexual Abuse in <u>Younger</u> Children

- Wetting pants, wetting bed, or fecal soiling
- Eating disturbances such as overeating, under eating
- Fears or phobias
- Compulsive Behaviors
- School problems or significant change in school performance (attitude and grades)
- Age-inappropriate behavior, including pseudo-maturity 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

Behavioral indicators of Sexual Abuse in Older Children and Adolescents:

- Withdrawal, clinical depression, apathy, chronic fatigue
- Overly compliant behaviors
- Poor hygiene or excessive bathing
- Poor peer relations and/or social skills; inability to make friends; non-participation in sports and social activities
- Acting out; running away; aggressive or delinquent behavior
- Alcohol or drug abuse
- Prostitution or excessive promiscuity
- School problems, frequent absences, sudden drop in school performance
- Refusal to dress for physical education
- Fearfulness of showers or restrooms; of home life, as demonstrated by arriving early and leaving late to school or to other familiar activities; of males (by females)
- 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

Physical Indicators of Neglect

- 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 order
- Unattended medical or dental conditions (e.g., infections, impetigo)
- Evidence of poor or inadequate supervision for the child's age

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, soda for lunch or consistently "forgets" to bring food

III. Definitions

Physical Abuse: Characterized by physical injuries (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.

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.

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 health is endangered, including the intentional failure to provide adequate food, clothing, shelter, or medical care.

Sexual Abuse: Refers to sexual assault or sexual exploitation
Sexual assault includes rape, statutory rape, and 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 or another person
- Any intrusion by one person into the genital or anal opening or another person, including the use of any object for this purpose, excepting acts performed for 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 or a child (P.C. 11165.1[b])

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, aides, 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 others 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 or 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 331.3 (P.C. 11165.1[c])

ATTACHMENT: Child Abuse Reporting Instructions and Forms

SECTION	Approval date:	
Office Management	Approved by:	
POLICY AND PROCEDURE	Effective date:	
Cultural and Linguistics	Revision date:	

CULTURALLY COMPETENT SERVICES

POLICY:

All patients shall be assessed for cultural and ethnic characteristics that may affect behaviors and treatment. All clinical staff shall demonstrate understanding of cultural and ethnic variances related to illness and care of patients. Every effort shall be made to adapt services to meet specific needs within cultural and ethnic differences. These differences may affect communication, activities of daily living, food practices, beliefs about medicines and healing, responses to pain and touch, birth and death rituals, family relationships and spiritual health practices.

PROCEDURE:

1. All staff shall demonstrate sensitivity to different culture and ethnic backgrounds especially when caring for patients with different cultural and ethnic needs.

2. Providing services to persons with different cultural and ethnic backgrounds:

    a. The most effective tool in working with patients from other cultural and ethnic background is respect. Patients may pick up quickly when there is a tone of condescension of judgement that comes from a staff person. Negative non-verbal communication is powerful in rendering ineffective care. Be open to understanding the patient's unique perspective and experiences.
    b. Accept responsibility for any misunderstanding that may occur rather than expecting the patient to bridge the cultural and ethnic gap.
    c. Do not assume anything about anyone, even though you are "well-read" about the practices of a particular group. Be willing to admit that you do not know. Remember, you are in an insider to your own culture and an outsider to another ethnicity and culture.
    d. If a staff or provider has difficulty working with patients from another culture, that staff or provider must assess and address those barriers when working with patients from that culture.
    e. The more conscious you are of your own biases, the more open minded and understanding you can be.
    f. Assume there are good reasons for why patients do what they do. There are often a variety of factors that can influence decisions patients make that you may not be privy to.
    g. Listen actively and carefully. Listen not only for factual information but closely watch the patient's reaction. Notice what the patient asks about. Stop talking as soon as the patient seems they have something to say. Accept silence as a natural part of conversation.
    h. Give non-judgmental feedback to be sure you heard what you thought you heard. Be careful about how literal you take things and how literal your statements might be taken.
    i. Expect to enjoy meeting patients with experiences different from your own. There may be times when we seek out the familiar people and things but cultural venturing can be stimulating and gratifying.
    j. Notice and remember what patients call themselves. Be a bit on the formal side at first in language and behavior until you are more acquainted. Be sure to remain professional whether more formal or more casual.
    k. If it appears to be appreciated, act as a cultural guide-coach to the patient. Look for ethnic and cultural guides or coaches, to help you put things in perspective. Ask

questions. Some people appreciate interest in their experiences. Be careful, though, because asking questions may have a judgement tone, implying that the thing you ask is not acceptable.

l. If someone speaks more loudly than you, or stands more still, adjust your behavior. Watch cultural groups interacting among themselves, and learn what their norms are.

3. What Successful Communicators Never Do

   a. Never make assumptions based on a person's appearance, name, and membership in a group. Do not expect people of a group to look, act and think alike.
   b. Never show amusement or shock at something that is strange to you.
   c. Never imply that the established way of doing things is the only way or the best way. This refers to lifestyles, not laws, rules or regulations.

LINGUISTIC SERVICES

POLICY:

According to the Department of Justice, "People who are completely bilingual are fluent in two languages. They are able to conduct the business of the workplace in either of those languages. Bilingual staff can assist in meeting the Title VI and Executive Order 13166 requirement for federally conducted and federally assisted programs and activities to ensure meaningful access to LEP (limited English proficient) persons."

"One of the primary ways that bilingual staff can be used as part of a broader effort to ensure meaningful access is to have them conduct business with the agencies' LEP clients directly in the clients' primary language." "This is sometimes called "monolingual communication in a language other than English."

An interpreter is defined as a person who provides immediate communication of meaning from one language (the source language) into another (the target language). An interpreter is usually a third party who interprets between speakers who speak different languages.

The site has 24-hour access to interpreter services for non-/LEP members and the hearing impaired.

PROCEDURE:

1. Staff shall ensure that interpreter services are made available in identified threshold languages specified for location of site.

2. All personnel providing language interpreter services on site are trained/competent in medical interpretation.

3. The provider/designee shall assess interpreter skills and capabilities of their staff providing interpreter services using at least one or more of the following (please check all that apply):
   - ☐ 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 specified type of interpreter training programs, i.e., medical, legal, court, or semi-technical; OR
   - ☐ Other reasonable alternative documentation of interpreter capability as specified below:

     _____
     _____

4. Staff shall document in the medical record any request for, or refusal of, language interpreter services and the name of the interpreter.

5. The PCP shall ensure that 24-hour language and hearing-impaired interpreter services are available for all members either through telephone/video language services or interpreters on site.

The following lists the threshold languages (other than English) spoken by non-/LEP members on site:

_____

_____

The following table lists all bilingual providers and staff on site who are deemed capable and competent as interpreters based on the assessment above. Please use additional pages as needed.

Name of Provider/Staff	Title	Language(s) of fluency other than English

RESOURCES: Caring for Diverse Populations Toolkit
Interpreter Services Desktop Reference

ATTACHMENT: Employee Language Skills Self-Assessment Tool
Request for / Refusal of Language Interpreter Services (sample)

SECTION	Approval date:	
Office Management	Approved by:	
POLICY AND PROCEDURE	Effective date:	
Disability Rights and Provider Obligations	Revision date:	

POLICY:

Section 504 of the Rehabilitation Act of 1973 is a national law that protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to employers and organizations that receive financial assistance from any Federal department or agency, including the U.S. Department of Health and Human Services (DHHS).

Section 504 forbids organizations and employers from excluding or denying individuals with disabilities an equal opportunity to receive program benefits and services. It defines the rights of individuals with disabilities to participate in, and have access to, program benefits and services.

Under this law, individuals with disabilities are defined as persons with a physical or mental impairment which substantially limits one or more major life activities. People who have a history of, or who are regarded as having a physical or mental impairment that substantially limits one or more major life activities, are also covered. Major life activities include caring for one's self, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning. Some examples of impairments which may substantially limit major life activities, even with the help of medication or aids/devices, are: AIDS, alcoholism, blindness or visual impairment, cancer, deafness or hearing impairment, diabetes, drug addiction, heart disease, and mental illness.

Section 504 prohibitions against discrimination apply to service availability, accessibility, delivery, employment, and the administrative activities and responsibilities of organizations receiving Federal financial assistance. A recipient of Federal financial assistance may not, on the basis of disability:

- Deny qualified individuals the opportunity to participate in or benefit from federally funded programs, services, or other benefits.
- Deny access to programs, services, benefits or opportunities to participate as a result of physical barriers.

Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). The law prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in health programs or activities that receive Federal financial assistance or are administered by an Executive agency or any entity established under Title I of the ACA. Section 1557 has been in effect since enactment of the ACA. The Section 1557 final rule applies to recipients of financial assistance from the Department of Health and Human Services (HHS), the Health Insurance Marketplaces and health programs administered by HHS.

The final rule is consistent with existing directives implementing the requirements under the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973. It requires effective communication, including through the provision of auxiliary aids and services; establishes standards for accessibility of buildings and facilities; requires that health programs provided through electronic and information technology be accessible; and requires covered entities to make reasonable modifications to their policies, procedures, and practices to provide individuals with disabilities access to a covered entity’s health programs and activities.

The final rule requires all covered entities to post a notice of consumer civil rights; covered entities with 15 or more employees are also required to have a civil rights grievance procedure and an employee designated to coordinate compliance. Under a new requirement, covered entities are required to post information telling consumers about their rights and telling consumers with disabilities and consumers with limited English proficiency (LEP) about the right to receive communication assistance.

According to Title 28, Code of Federal Regulations (CFR), section 35.151, 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. 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. The site shall 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.

PROCEDURE:

1. A notice of consumer civil rights/nondiscrimination shall be posted in a prominent location in the clinic (see sample notice below).
2. The clinic has the following safety accommodations available for physically disabled persons or has an alternative plan in place for making program services available to persons with physical disabilities (see checked items that apply):
    - ☐ Parking spaces for persons with physical disabilities are located in close proximity to accessible building entrances.
    - ☐ Each parking space reserved for persons with disabilities is identified by a permanently affixed reflectorized sign posted in a conspicuous place; or reasonable alternative if the provider has no control over availability of accessible parking within the lot or nearby street spaces for persons with disabilities: _____ _____
    - ☐ Pedestrian ramps with a clear and level landing at the top and bottom of all ramps and on each side of an exit door – if the clinic has multiple levels.
    - ☐ Exit and exam room doorway openings have minimum opening of 32 inches with the door open at 90 degrees to allow for clear passage of a person in a wheelchair; or reasonable alternative: _____
    - ☐ Door hardware is operable with a single effort without requiring ability to grasp hardware (latch or push-bars instead of door knobs)
    - ☐ Effort to operate interior doors do not exceed 5 pounds of pressure
    - ☐ Furniture and other items do not obstruct exit doorways or interfere with door swing pathway
    - ☐ Accessible passenger elevator for multi-level floor accommodation; or reasonable alternative: _____
    - ☐ Clear floor space (at least 30-in. x 48-in.) for wheelchair in waiting area and exam room to accommodate a single, stationary adult wheelchair and occupant; and a minimum clear space of 60-inch diameter or square area to turn a wheelchair; or reasonable alternative: _____
    - ☐ Wheelchair accessible restroom facilities are available; or reasonable alternative: _____
    - ☐ Wheelchair accessible handwashing facilities are available; or reasonable alternative: _____
    - ☐ A 24-hour language and hearing-impaired interpreter services are available for all members either through telephone/video language services or interpreters on site
    - ☐ Other accommodations or specialized equipment (i.e., heigh adjustable exam tables, wheelchair accessible weight scales, signage in raised letters and Braille, etc.): _____ _____
3. If any patient feels that they have been subject to discrimination in health care or health coverage, they may file a complaint of discrimination under Section 1557. They are encouraged to visit the Office of Civil Right's (OCR's) website at www.hhs.gov/ocr to file a complaint or to

request a complaint package, or call OCR's toll free number at (800) 368-1019 or (800) 537-7697 (TDD) to speak with someone who can answer their questions and guide them through the process. OCR's complaint forms are available in a variety of languages. Individuals can also file lawsuits under Section 1557.

4. For sites with 15 or more employees – A civil rights grievance procedure is followed:
    a. The employee designated to coordinate compliance is: _____
    b. All civil rights discrimination complaints shall be processed following the site's *Member Grievances/Complaints* policy.
5. All site personnel shall receive information and/or training on patient rights and provider obligations under the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and/or Section 1557 of the Affordable Care Act.
6. Training content includes information about physical access, reasonable accommodations, policy modifications, and effective communication in healthcare settings.

RESOURCES:

https://www.hhs.gov/sites/default/files/ocr/civilrights/resources/factsheets/504.pdf
https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html#tagline
https://www.ecfr.gov/search
Physical Accessibility Review Survey Information and Tools

For more information about translated notices and taglines:
https://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html

ATTACHMENTS: Notice of Civil Rights / Nondiscrimination (for clinics with less than 15 employees) (sample)
Notice of Civil Rights / Nondiscrimination (for clinics with 15 employees or more) (sample)

SECTION	Approval date:	
Personnel	**Approved by:**	
POLICY AND PROCEDURE	**Effective date:**	
Domestic Violence Reporting	**Revision 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

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

A **telephone report** must be made **immediately** or as soon as practically possible, without delay.

A **written report** is to be made **within two working days** of receiving the information using OCJP 920: Suspicious Injury Report Form (see attachment). 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 injures
- The identity of the person who allegedly inflicted the injury

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 $1000, or both

Check with the local law enforcement agency of where to report if the patient was injured in another county

<u>If the battered patient is a minor then the Child Abuse and Neglect Reporting Act applies. (see Child Abuse Reporting policy and procedure)</u>

II. **MEDICAL RECORD**

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

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)

Patient Safety

- Address directly the risk of retaliation by the batterer and discuss hot 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

Referral

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

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 the shelter lines to learn how to file a "Good Cause Report" which can protect them from kidnapping charges

IV. DEFINITIONS

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 f spouse of cohabitant, sodomy, oral copulation and an attempt to commit any of these crimes

ATTACHMENTS: Domestic Abuse and Suspicious Injury Reporting Instructions and Forms

SECTION	Approval date:	
Personnel	Approved by:	
POLICY AND PROCEDURE	**Effective date:**	
Elder and Dependent Adult Abuse Reporting	**Revision 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

Reports must be made both by telephone and in writing.

A **telephone report** must be made **immediately** or as soon as practically possible, without delay.

A written report is to be made within two business 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

All of the following types of abuse must be reported:

- Physical Abuse
- Abandonment
- Isolation
- Abduction
- Financial Abuse
- Neglect (including self-neglect)

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.

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.

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.

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.

A single report may be made when two or more persons have knowledge of a suspected instance of abuse

II. **Exceptions to Reporting Requirement**

There are exceptions to the requirement to report:

Reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred

The elder of 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

The reporter reasonably believes that the abuse did not occur

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

Physical Signs

Injury that has not been cared for properly

Injury that is consistent with explanation for cause

Pain from touching

Cuts, puncture wounds, burn, bruises, welts

Dehydration or malnutrition without illness-related cause

Poor coloration

Sunken eyes or cheeks

Inappropriate administration of medication

Soiled clothing or bed

Frequent use of hospital or health care/doctor shopping

Lack of necessities such as food, water, or utilities

Lack of

Personal effects, pleasant living environment, personal items

Forced isolation

Behavioral Signs

Fear

Anxiety, agitation

Anger

Isolation, withdrawal

Depression

Non-responsiveness, resignation, ambivalence

Contradictory statements, implausible stories

Hesitation to talk openly

Confusion or disorientation

Signs by Caregiver

Prevents elder from speaking to or seeing visitors

Anger, indifference, aggressive behavior toward elder

History of substance abuse, mental illness, criminal behavior, or family violence

Lack of affection toward elder

Flirtation or coyness as possible indicator of inappropriate sexual relationships

Conflicting accounts of incidents withholds affection

Withholds affection

IV. Definitions

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 care or custody

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 conservatee without the consent of the conservator or court

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 are necessary to avoid harm or mental suffering.

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 developmental disabilities have diminished because of age as well as any 10- to 64-year-old who is admitted as an impatient to a 24-hour healthcare facility

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

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

Goods and services: Include 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

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

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

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

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

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

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

ATTACHMENTS: Elder/Dependent Adult Abuse Reporting Instructions and Forms

SECTION	Approval date:	
Access/Safety	**Approved by:**	
POLICY AND PROCEDURE	**Effective date:**	
Emergency Medical Procedures	**Revision 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**

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:

A. A wall oxygen delivery system or secured portable oxygen tank maintained at least ¾ full. An oxygen delivery system which includes population-appropriate size (pediatric and adult): ambu-bag with face mask that creates proper seal, nasal cannula or oxygen mask, tubing, and bulb syringe.
   - 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, ½, ¾, 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.

B. Benadryl 25 mg (oral) or Benadryl 50 mg/ml (injectable), Epinephrine 1:1000 (injectable), Naloxone, chewable aspirin 81 mg (at least 4 tablets), nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), glucose, appropriate sizes of ESIP syringes and alcohol wipes.

C. Emergency medication dosage chart (see attached).

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

The supplies and equipment shall be checked for expiration and operating status at least monthly. Staff responsible for checking the equipment/supplies shall document:
- The date the supplies/equipment were checked, and
- His/her initials verifying that equipment is in working order, the oxygen tank is at least ¾ full, the supplies are within expiration date and the medication dosage chart is present.

Replacing/restocking supplies:

- An extra oxygen tank will be maintained onsite -OR- each time the oxygen tank is used, the remaining supply will be checked. If the tank is ¾ or less full, the supplier will be called to replace the used tank with a full tank.
- The month prior to the noted expiration date, the supplies/medication will be ordered to ensure delivery before the supplies actually expire.
- The medication and supplies will be ordered and or replaced immediately after use.

II. EMERGENCY SERVICES TRAINING

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

- Describe facility-specific actions, and
- Locate written emergency procedures and information.

Training shall be completed upon hire and when updates to policy are made.
Training shall be documented.

III. EMERGENCY INFORMATION

Emergency phone numbers will be posted in an accessible and prominent location (e.g., front and back office). 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).

Emergency phone number list shall be dated, and telephone numbers updated annually and as changes occur.

IV. EMPLOYEE ALARM/ALERT SYSTEM

In the event of a fire or other emergency, employees are notified as soon as possible using the employee alarm/alert system (e.g., manual pull box alarms, public address systems, radio, telephones). Back-up means of alarm/alert (e.g., employee runners, air horns) shall be provided when systems are out of service. For those with 10 or fewer employees, direct voice communication is acceptable (provided all employees can hear the alarm or alert) and do not need a back-up system.

Type of Emergency Employee Alarm/Alert System used on site: _____
Back-up system: _____

ATTACHMENTS: Emergency Protocol and Contact List (sample)
Emergency Kit Inventory Log (sample)
Emergency Medication Dosage Chart (sample)

SECTION	Approval date:	
Access/Safety	**Approved by:**	
POLICY AND PROCEDURE	**Effective date:**	
Fire Safety and Prevention and Emergency Non-Medical Procedures	**Revision 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 and prevention and emergency non-medical procedures.

PROCEDURE:

I. **SAFE ENVIRONMENT**

The provider/designee will ensure the following fire and safety precautions:

- Lighting is adequate in all areas
- Exit doors and aisles are unobstructed and egress (escape) accessible.
- Exit doors are clearly marked with "Exit" signs.
- Clearly diagrammed "Evacuation Routes" for emergencies are posted in visible locations.
- Electrical cords and outlets are in good working condition
- At least one type of firefighting/protection equipment is accessible at all times

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**

Fire Safety and Prevention and Non-Medical Emergency information shall be available on site. Staff shall be informed of the location of the information and how to use the information. Staff training on fire safety and prevention and emergency non-medical procedures are verifiable and may be part of staff education documented in:

- Informal or formal in-services
- New staff orientation
- External training courses

Fire Safety and Prevention and Non-Medical Emergency procedure training topics shall include:

- Evacuation routes and exits for the exam rooms, office suites, and building
- Evacuation procedures
- Location of fire alarms, extinguishers, sprinklers, and smoke detectors
- Emergency phone numbers
- Workplace violence procedures *including emergency numbers*

ATTACHMENTS: Workplace Violence Protocol (sample)
Emergency Earthquake Plan (sample)
Emergency Fire Plan (sample)
Site Evacuation Plan (site specific)

SECTION	Approval date:	
Infection Control	Approved by:	
POLICY AND PROCEDURE	Effective date:	
Infection Control / Standard and Universal Precautions	Revision 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, HCV, and other blood borne pathogens. "Universal precautions" refers 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 wipes 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 is acceptable for general patient care (Association for Professionals in Infection Control and Epidemiology, Inc., 1995).

Hand Hygiene: Why, How & When? (who.int)

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.

B. Hands shall be washed with soap and water when they are visibly soiled or after healthcare personnel have been in contact with patients with diarrheal illnesses such as Norovirus or *C. difficile*. As a precaution, wash with soap and water when in contact with any diarrheal illness.

III. Personal Protective Equipment (PPE)

A. PPE is specialized clothing and/or equipment for protection against blood borne 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,

- Water repelling gloves
- Clothing barrier (e.g., gown, sheets)
- Face/eye protection (e.g., goggles, face shield)
- 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.

D. The storage of PPE should be adequate to protect the PPE from contamination, loss, damage, water or sunlight. Proper storage often requires a dry and clean place that is not subject to temperature extremes.

IV. Contaminated Laundry

A. 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. Manufacturer's guidelines are followed to decontaminate and launder reusable protective clothing, linens and other reusable barriers. Ensure that laundry areas have handwashing facilities and products and appropriate PPE available for staff. Laundry requirements are "not applicable" if only disposable patient gowns, linens and PPE are used on site.

V. 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.

A. Airborne precautions:
1. Have patient enter through a separate entrance to the facility (e.g., dedicated isolation entrance), if available, to avoid the reception and registration area;
2. Provide a facemask (e.g., procedure or surgical mask) to the patient and place them immediately in an airborne infection isolation room (AIIR);
3. If an AIIR is not available, place the patient immediately in an exam room with a closed door. Turn off air condition/heating equipment that may circulate the air from the isolation room into other patient areas within the facility;
4. Instruct the patient to keep the facemask on while in the exam room, if possible, and to change the mask if it becomes wet; and
5. Initiate protocol to transfer patient to a healthcare facility that has the recommended infection-control capacity to properly manage the patient;

6. PPE use:
    - Wear a fit-tested N-95 or higher level disposable respirator, if available, when caring for the patient; the respirator should be donned prior to room entry and removed after exiting room
    - If substantial spraying of respiratory fluids is anticipated, gloves and gown as well as goggles or face shield should be worn

7. Perform hand hygiene before and after touching the patient and after contact with respiratory secretions and/or body fluids and contaminated objects/materials;
8. Use soap and water when hands are visibly soiled (e.g., blood, body fluids);
9. Instruct patient to wear a facemask when exiting the exam room, avoid coming into close contact with other patients, and practice respiratory hygiene and cough etiquette;
10. Once the patient leaves, the exam room should remain vacant for generally one hour before anyone enters; however, adequate wait time may vary depending on the ventilation rate of the room and should be determined accordingly; and
11. If staff must enter the room during the wait time, they are required to use respiratory protection.

B. Droplet Precautions

1. Provide the patient with a facemask and place the patient in an exam room with a closed door as soon as possible (prioritize patients who have excessive cough and sputum production); if an exam room is not available, the patient is placed in a separate area as far from other patients as possible while awaiting care;
2. PPE use:
    - Wear a facemask, such as a procedure or surgical mask, for close contact with the patient; the facemask should be donned upon entering the exam room
    - If substantial spraying of respiratory fluids is anticipated, gloves and gown as well as goggles (or face shield in place of goggles) should be worn;
3. Perform hand hygiene before and after touching the patient and after contact with respiratory secretions and contaminated objects/materials; *note:* use soap and water when hands are visibly soiled (e.g., blood, body fluids);
4. Instruct patient to wear a facemask when exiting the exam room, avoid coming into close contact with other patients, and practice respiratory hygiene and cough etiquette; and
5. Clean and disinfect the exam room accordingly.

C. Contact Precautions

1. Apply to patients with any of the following conditions and/or disease:
    - Presence of stool incontinence (may include patients with Norovirus, rotavirus, or Clostridium difficile), draining wounds, uncontrolled secretions, pressure ulcers, or presence of ostomy tubes and/or bags draining body fluids
    - Presence of generalized or diffuse rash;
2. Prioritize placement of patients in an exam room if they have stool incontinence, draining wounds and/or skin lesions that cannot be covered, or have uncontrolled secretions;
3. Perform hand hygiene before touching patient and prior to wearing gloves;
4. PPE use:
    - Wear gloves when touching the patient and the patient's immediate environment or belongings
    - Wear a gown if substantial contact with the patient or their environment is anticipated;
5. Perform hand hygiene after removal of PPE; note: use soap and water when hands are visibly soiled (e.g., blood, body fluids), or after caring for patients with known or suspected infectious diarrhea (e.g., Clostridium difficile, Norovirus);
6. Clean/disinfect the exam room accordingly; and

7. Instruct patients with known or suspected infectious diarrhea to use a separate bathroom, if available. Clean/disinfect the bathroom before it can be used again.

VI. Waste Disposal Container

A. Contaminated wastes (e.g., dental drapes, bandages, 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.

B. Blood and Other Potentially Infectious Materials (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.

SECTION	Approval date:	
Personnel	Approved by:	
POLICY AND PROCEDURE	Effective date:	
Informed Consent	Revision date:	

POLICY:

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

PROCEDURE:

I. 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.

II. 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

III. Informed Consent

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, Title 22, California Code of Regulations, Section 70707 and Medicare Conditions of Participation.

Requirements include but 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 they 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 human 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: 916-928-1328

NOTE: Department of Health Care Services COB Letter 87-1 revision 2 and Title 22 code or regulations Sections 51163 and 501305.1-513-5.7 define Medi-Cal Sterilization and Hysterectomy Regulations and Procedures.

ATTACHMENT: Consent for Sterilization (sample)

SECTION	Approval date:	
Office Management	Approved by:	
POLICY AND PROCEDURE	Effective date:	
Member Grievances/Complaints	Revision date:	

POLICY:

The site has an established process for member grievances and complaints.

DEFINITION:

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 shall 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:

- The California Department of Managed Health Care: 1-888-HMO-2219 (1-888-466-2219)
- The Office of the Ombudsman: 1-888-452-8609
- For Hearing and Speech impaired persons call: 1-800-735-2929
- State Fair Hearing: 1-800-952-5253

B. Staff shall ensure that grievance forms (in threshold languages) for each participating health plan shall be provided to members promptly upon request.
- The grievance form must be submitted to the health plan within one (1) business day

C. The staff shall ensure that all complaints (e.g., service complaints, appointment wait times) are tracked and submitted to the health plan after each occurrence.

- These complaints may be resolved at the point of service
- Log the complaint to include the following information:
  a. Date of complaint
  b. Name of complainant and ID#
  c. Nature of the complaint
  d. Resolution/action taken (include information communicated to health plan, as appropriate)
  e. Date of resolution/action
  f. Date log submitted to health plan

ATTACHMENTS: Member Grievance Form (English)
Member Grievance Form (Spanish)
Member Grievance Log (sample)

SECTION	Approval date:	
Office Management	Approved by:	
POLICY AND PROCEDURE	Effective date:	
Minor's Rights and Sensitive Services	Revision date:	

POLICY:

Site personnel receive training and/or information on member rights that include minors' rights to sensitive services.

PROCEDURE:

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

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

III. Minors' Rights and Sensitive Services

A. A minor may consent to the minors' 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 separately 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

B. A physician, 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 the minor, the whereabouts of the parent or guardian.

C. 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 Public Health Officer. A minor who is 12 years of age or older may consent to medical care related to the prevention of a sexually transmitted disease.

D. A minor who is 12 years of age or older and who is alleged to have been raped may consent to medical care related to the diagnosis or treatment of the condition and the collection of medical evidence with regard to the alleged rape.

E. A minor who is alleged to have been sexually assaulted may consent to medical care related to the diagnosis and treatment of the condition, and the collection of medical evidence with regard to the alleged sexual assault. The professional person providing medical treatment shall attempt to contact the minor's parent or guardian and shall note in the minor's treatment record the date and time the professional person attempted to contact the parent or guardian and whether the attempt was successful or unsuccessful. This does not apply if the professional person reasonably believes that the minor's parent or guardian committed the sexual assault on the minor.

F. A minor who is 12 years of age or older may consent to medical care and counseling relating to the diagnosis and treatment of a drug- or alcohol-related problem.

G. A minor who is 12 years of age or older and who states that the minor is injured as a result of intimate partner violence may consent to medical care related to the diagnosis or treatment of the injury and the collection of medical evidence with regard to the alleged intimate partner violence.

H. Special precautions must be taken to ensure that communications (written, verbal or electronic communications) regarding the medical information of a minor related to sensitive services is protected and shall NOT be directed to the home without the minor's authorization.

1. Communications are directly to minor's designated alternative mailing address, email address, or telephone number; OR,
2. In the absence of a designated alternative mailing address, email address, or telephone number: to the address or telephone number on file in the name of the minor.
3. Communications regarding a protected minor's receipt of sensitive services shall include:
   - Bills and attempts to collect payment.
   - A notice of adverse benefits determinations.
   - An explanation of benefits notice.
   - A plan's request for additional information regarding a claim.
   - A notice of a contested claim.
   - The name and address of a provider, description of services provided, and other information related to a visit.
   - Any written, oral, or electronic communication from a plan that contains protected health information.

I. The minors' parents or guardian are not liable for payment for medical care provided pursuant to this section.

RESOURCES: California Law Family Code Section 6920-6930
Civil Code Section 56 et seq.

ATTACHMENT: California Minor Consent and Confidentiality Laws

SECTION	Approval date:	
Office Management	Approved by:	
POLICY AND PROCEDURE	Effective date:	
Patient Confidentiality	Revision date:	

POLICY:

Confidentiality of personal medical information is protected according to state and federal guidelines. Patients have the right to privacy for dressing/undressing, physical examination, and medical consultation. Practices are in place to safeguard patient privacy. The patient's private health information shall be maintained secure and confidential in compliance with legal, accrediting and regulatory agency requirements. All member information is regarded as confidential and obtainable only to authorized persons.

PROCEDURE:

A. The primary care provider (PCP) site shall 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. Patient registration sign-in sheets protect patient's privacy from other patients who may also be checking-in for their appointments. Patient sign-in sheets shall collect only minimal information using no more than one (1) patient identifier such as the patient's name.

B. The PCP site shall ensure that exam rooms and dressing areas safeguard patient's right to privacy.

C. The provider/designee shall ensure that there is a system for the following:
   1. Medical records are available at each encounter and include outpatient, inpatient, referral services, and significant consultations.
   2. Medical records are accessible within the facility, or an approved health record storage facility on the facility premises.

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, idle monitor screen protection and blinded files.

E. The PCP site shall 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. NOTE: The PCP site shall release and furnish necessary health records without the patient's written, signed consent to coordinate the patient's care with physicians, hospitals, or other health care entities, or to coordinate payment. PCPs shall also provide at no charge to health plans and appropriate state and federal regulators without written, signed consent from the patient, prompt access or upon demand, to medical records or information for quality management or other purposes, including utilization review, audits, reviews of complaints or appeals, HEDIS and other studies within 10 days of the request unless otherwise indicated or as agreed upon.

F. Transmittal of medical records by email shall be encrypted at all times. Transmission of medical records by fax shall include a fax cover page. The fax cover page includes a confidentiality statement which requires the recipient to maintain the information in a safe, confidential and secure manner and provide instructions on what steps to take when the transmittal is received by unintended recipients.

G. The PCP site shall ensure that medical records are retained for a minimum of 10 years following patient encounter.

H. The name of the individual delegated the responsible for securing and maintaining the security of medical records at this location is: _____

SECTION	Approval date:	
Office Management	**Approved by:**	
POLICY AND PROCEDURE	**Effective date:**	
Referrals Process / Prior Authorizations	**Revision date:**	

POLICY:

Referrals for specialty care and medical procedures shall be processed in a timely manner.

PROCEDURE:

I. REFERRAL FORMS

A. 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 to obtain prior authorization from the entity responsible for payment as necessary. Refer to the 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.

C. The following elements should be included within the referral system:
- Patient Name
- Date of Referral
- Referral Type
- Authorization Status
- Appointment Date
- Appointment Kept or Failed
- Date Report Received
- Physician Follow-up/Documentation

D. The PCP must ensure timely receipt of the specialist's report or medical procedure report. Reports must be filed in the patient's medical record within 30 days of the scheduled procedure or appointment. If the PCP site has not received the report within 30 days, the PCP should contact the specialist/procedure site to request a copy of the report.

E. Site staff shall be able to demonstrate (e.g., "walk-through") the office referral process from beginning to end.

ATTACHMENT: Referral Tracking Log - Blank
Referral Tracking Log - Sample

SECTION	Approval date:	
Infection Control	**Approved by:**	
POLICY AND PROCEDURE	**Effective date:**	
Sanitary Environment and Decontamination of Surfaces	**Revision date:**	

POLICY:

Site environment shall be maintained in a clean and sanitary condition. Environmental safety includes the hygienic condition of the site. The site shall follow decontamination procedures on contaminated surfaces according to Cal-OSHA Standards, 8 CCR §5193; CA HandS Code §118275. The site shall utilize products from the most current EPA approved product list and information available from the EPA, Antimicrobial Division's website at https://www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants

PROCEDURE:

I. General Appearance

A. Patient areas, restrooms, furniture, walls, floors, and carpets shall be unsoiled, neat, tidy, uncluttered, and in good repair.
   1. Cleaning shall be performed regularly, as scheduled, by staff or contracted service.
   2. Staff is responsible for keeping work areas neat and clean.
   3. Staff is responsible for reporting to the office manager/provider any soiled carpet, walls, etc. that require professional cleaning, repair, or replacement. Designated staff shall arrange for appropriate services, as needed.
   4. Staff is responsible for reporting to the office manager/provider if any equipment, furniture, carpet, etc. is in need of repair (i.e., torn upholstery covers, etc.). Designated staff shall arrange for repair or replacement, as needed.

II. Sanitary Supplies

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

III. Hand Washing Facilities and Antiseptic Hand Cleaner

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 wipes 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).

C. Antimicrobial agents or alcohol-based antiseptic hand rubs shall be 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.

Hand Hygiene: Why, How & When? (who.int)

IV. 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.

V. Disinfectant Products

A. Products used for decontamination have a current EPA-approved status. Product shall 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."

VI. 10% Bleach Solution

A. If 10% bleach solution is used (using a minimum of 5.25% sodium hypochlorite concentration), 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) inactivating active ingredient, sodium hypochlorite. Surface is air dried or allowed appropriate time (stated on label) before wiping it dry and use. Manufacturer's directions, *specific* to every bleach product, are followed carefully.

VII. Waste Disposal Container

A. Contaminated wastes (e.g., dental drapes, band aids, sanitary napkins, soiled disposable 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. (California Health and Safety Code Section 118275-118320) https://www.hercenter.org/rmw/osha-bps.php

B. Blood and Other Potentially Infectious Materials (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.

VIII. Spill Procedure

A. Staff is able to identify procedures for prompt decontamination of blood/body fluid spills, the Personal Protective Equipment (PPE) and disinfectant used, and the responsible person(s).

B. PPE for protection against bloodborne pathogen hazards is available on site and shall include: 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 will 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. The storage of PPE are adequate to protect the PPE from contamination, loss, damage, water or sunlight. Proper storage often requires a dry and clean place that is not subject to temperature extremes.

RESOURCES: Bleach Comparison Chart with CDC Guidelines

ATTACHMENTS: Cleaning Schedule (sample)
Cleaning Log (sample)
Bleach Labels (sample)

SECTION	Approval date:	
Office Management	Approved by:	
POLICY AND PROCEDURE	Effective date:	
Access to Care 24/7	Revision date:	

POLICY:

The site shall have a provision for appropriate, coordinated access to health care services 24 hours a day, seven (7) days a week.

PROCEDURE:

A. The staff shall ensure that current clinic office hours are posted within the office or readily available upon request.

B. The PCP shall ensure that the following current site-specific resource information are available to site personnel:
   1. Physician office hour schedule(s),
   2. Group and/or Plan-specific systems for after-hours urgent care,
   3. Emergent provider/on-call coverage available 24 hours a day, 7 days per week, and
   4. A system for providing follow-up care.

C. When the PCP is not on site during regular office hours, personnel are able to contact the provider (or covering provider) at all times by telephone, cell phone, pager, etc.

D. During after-hours or when the PCP is not on site during regular office hours, the PCP (or covering provider) shall respond to urgent/emergent member matters within 30 minutes.

E. Telephone answering machine, voice mail system or answering service are used whenever office staff does not directly answer phone calls.

F. Telephone system, answering service, recorded telephone information, and recording device are periodically checked and updated to ensure functionality and validity of information:
   - ☐ Monthly
   - ☐ Quarterly
   - ☐ Other: _____

G. After-hours emergent, urgent and routine care instructions/clinic information are made available to patients. The site has the following answering service/machine greeting and instructions (if different from below, see attached script):

"*You have reached the office of* _____ (Clinic/PCP name). *Our office is currently closed. If this is a life-threatening emergency, hang up and call 911 or go to the nearest emergency room. If this is an urgent matter and you need to speak to the doctor, please call* _____ (provider's after-hours phone or pager number). *Your call will be returned within 30 minutes. For routine matters such as appointments or prescription refills, please leave a message after the tone. Please be sure to include your name and your telephone number with the area code. We will return your call during our normal office hours. Our normal office hours are* _____ (day) *through* _____ (day), _____ (opening time) *until* _____ (closing time)."

SECTION	Approval date:	
Medical Records Documentation	**Approved by:**	
POLICY AND PROCEDURE	**Effective date:**	
Advance Health Care Directive	**Revision date:**	

POLICY:

Adults 18 years of age or older and emancipated minors shall be offered information or has executed an Advance Healthcare Directive (California Probate Code, Sections 4701).

PROCEDURE:

III. Advance healthcare directive (advance directive) shall be discussed with each member 18 years of age or older. State and Federal requirements shall 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 patient's 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. Health plan policies states that adult members, age 18 years or older, has the right to prepare an advance directive.

Discussing and pre-paring advance directives with patients can:

a) Ensure the care and services desired by the patients are provided according to his or her wishes, including the refusal of treatment.
b) Designate the person who is delegated to make decisions on the patient's behalf if he or she becomes incapable of making such decisions.
c) Ensure family and friends abide by the wishes of the patient regarding the type of care and treatment determined in advance.

IV. DOCUMENTATION

Providers shall consider discussing advance directive during routine office visits with members, instead of waiting until a member is acutely ill. The Advance Medical Directive reference is available, in English and Spanish, and is attached to this policy.

If an advance directive is prepared by 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, if possible. A copy shall be in the medical record and updated every 5 years.

V. 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:

- www.chcf.org/topic/serious-illness-end-of-life-care/
- www.cancer.org/index

ATTACHMENTS: Advance Health Care Directive Information - Handout
Advance Health Care Directive Form (English)
Advance Health Care Directive Form (Spanish)

SECTION	Approval date:	
Office Management	**Approved by:**	
POLICY AND PROCEDURE	**Effective date:**	
Appointments and Patient Recall	**Revision 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 shall provide an initial health assessment (IHA) for each adult member within 120 days of the date of enrollment, 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 shall 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 members' names, addresses, and telephone numbers. If a member or guardian refuses to have an IHA performed, this information shall be documented in the member's medical record.

D. Staff shall follow up on missed and/or canceled appointments via mail or phone. At least three attempts shall be made and documented in the patient's record.

E. The PCP shall ensure that appointments are designed according to the patient's clinical needs and within the following timeliness standards:

1. Urgent Care: within 24 hours
2. Prenatal Care: within 7 days
3. Non-urgent Care: within 14 days
4. Well Baby Visits: within 14 days

SECTION	Approval date:	
Preventive Services	**Approved by:**	
POLICY AND PROCEDURE	**Effective date:**	
Health Education	**Revision date:**	

POLICY:

Health education services and Plan-specific resource information are available to Plan members.

PROCEDURE:

I. Health education materials will be maintained on site or made available upon request.
   A. Providers and/or staff will provide health education materials and/or resources to members as appropriate.

   B. 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.

II. Educational materials maintained on site will be applicable to the practice and the population served.

III. Educational materials will be available in threshold languages identified for county and/or area of site location.

RESOURCE: Member Education Materials

SECTION	Approval date:	
Infection Control	Approved by:	
POLICY AND PROCEDURE	Effective date:	
Instrument Sterilization	Revision date:	

POLICY:

This site will ensure that all reusable medical instruments are properly sterilized after each use.

PROCEDURE:

I. 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. Trained personnel will be able to demonstrate or verbally explain procedure(s) used for cleaning prior to sterilization, according to site-specific policy and/or manufacturer/product label directions.

II. COLD CHEMICAL STERILIZATION

The use of liquid cold chemical sterilants shall be restricted to reprocessing devices that are heat-sensitive and incompatible with other sterilization methods. All other items should be heat sterilized (using an autoclave) or disposable. 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 site-specific policy/procedures or Manufacturer's Instructions for cold sterilization are available on site for staff reference.

The OSHA Hazard Communication Standard requires manufacturers and importers of hazardous chemicals to develop Material Safety Data Sheets (MSDS) for each chemical or mixture of chemicals. MSDS for cold chemical sterilants shall be readily available on site to staff who work with the products to which they could be exposed. Staff shall attend training classes in safety awareness about the use and exposure to cold chemical sterilants used on site. Personnel are familiar with and is able to recognize signs and symptoms of exposure to cold chemical sterilants used on site. Staff shall be aware of the procedures and are able to perform the appropriate clean up in the event of spillage. The appropriate PPE for cold chemical sterilant clean-up shall be readily available.

III. AUTOCLAVE/STEAM STERILIZATION

The 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. If instruments/equipment are transported off-site for sterilization, equipment-handling and transport procedures are available on site to staff.

IV. AUTOCLAVE MAINTENANCE

A. The autoclave is maintained and serviced according to manufacturer's guidelines. The autoclave is serviced annually by a qualified technician, if the manufacturer's guidelines are not available. A dated sticker indicating the maintenance date will be placed on the autoclave or a service receipt will be kept on file to indicate documentation of mechanical problems, result/outcome of routine servicing, calibration, and repairs.

B. An autoclave instrument sterilization log shall be kept on file and shall include the following:
   - Date
   - Time
   - Duration of run cycle
   - Temperature
   - Steam pressure
   - Load identification information
   - Operator of each run

V. SPORE TESTING

A. Autoclave spore testing is performed *at least monthly*, unless otherwise stated in the manufacturer's guidelines. Spore testing reports shall be maintained on file and shall include the following:
   - Date
   - Results
   - Types of spore test used
   - Person performing/documentation test results

B. For positive spore tests, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs. The following procedures shall be followed with a positive spore test:
   1. **Report** problem to Office Manager or Doctor
   2. **Repair** autoclave
   3. **Retrieve** all instruments sterilized since last negative spore test
   4. **Re-test** autoclave
   5. **Re-sterilize** retrieved instruments

VI. STERILE PACKAGES

A. Storage areas for sterilized packages are maintained clean, dry, and separated from non-sterile items by a functional barrier (e.g., shelf, cabinet door, and drawer).

B. Sterilized package labels include:
   - Date of sterilization
   - Load run identification information
   - 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
   - Identity (initials or signature) of staff member who sterilized the instruments

C. Maintenance of sterility is event related, not time related. Sterilized items are considered sterile until use, unless an even causes contamination. Sterilized items are not considered sterile if package is opened, wet/moist, discolored, or damaged. Compromised packages shall be removed from sterile package storage area and immediately, repackaged, relabled and resterilized.

D. This site's process for routine evaluation of the integrity and condition of sterilized packages is as follows:
   ☐ Monthly inspection of sterile packages by assigned personnel
   ☐ Other: _____

ATTACHMENTS: Instrument Sterilization Log (sample)
Sterilized Packages Inspection Log (sample)

SECTION	Approval date:	
Clinical Services	Approved by:	
POLICY AND PROCEDURE	Effective date:	
Laboratory Services	Revision 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:

I. Laboratory test procedures are performed according to current site-specific CLIA certificate:
   A. All sites that perform laboratory testing for human health assessment, diagnosis, prevention, or treatment of disease, have a current, unrevoked, unsuspended site-specific 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 of Waiver. The current listing of waived tests may be obtained at http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/testswaived.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 DHS 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 of Medicare and Medicaid Services (CMS).

   B. CLIA certification/re-certification includes an evaluation every two years (or sooner, if complaint driven) by DHS of personnel licenses/training, laboratory site inspection and demonstration of testing proficiency of moderate and high-complexity test sites.

II. Testing personnel performing clinical lab procedures have been trained.
   A. 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.
   B. Site personnel that perform CLIA waived tests have access to and are able to follow test manufacturer's instructions.
   C. 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.
   D. The required training and certification are established by legislation (CA BandP 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.

III. Lab Supplies are inaccessible to unauthorized persons.

IV. Lab test supplies (e.g., vacutainers, culture swabs, test solutions) shall not be expired. Site follows the procedures below to monitoring for expiration date and a method of dispose of expired lab test supplies. A tracking log is the preferred method of tracking expiration dates (see Attachment).

Frequency of monitoring:	Method of disposal:
☐ Monthly, ☐ Weekly, or ☐ Other:	Describe:

V. The provider will review, initial, and date the original copy of each laboratory report, which is then filed in the member's medical record.

NOTE: For questions regarding CLIA certification, laboratory licensing, and personnel, call CA Department of Public Health Laboratory Field Services at (510) 620-3800.

ATTACHMENT: Monthly Potency Verification Log (sample)
Quality Control Log (sample)

SECTION	Approval date:	
Preventive Services	Approved by:	
POLICY AND PROCEDURE	Effective date:	
Lead Poisoning Prevention, Screening and Reporting	Revision date:	

POLICY:

According to the Centers for Disease Control and Prevention (CDC), protecting children from lead exposure is important to lifelong good health. Studies have shown that even low levels of lead in the blood can affect IQ, the ability to pay attention, and academic achievement. Lead exposure can cause damage to the brain and nervous system, slowed growth and development, learning and behavior problems, and hearing and speech problems. The most important step that can be taken is to prevent lead exposure before it occurs.

While lead paint has historically been the greatest source of lead exposure, children can be exposed to lead from additional sources such as lead smelters, leaded pipes, solder, plumbing fixtures, and consumer products. Lead can also be present in air, food, water, dust, and soil.

Federal law requires states to screen children enrolled in Medicaid for elevated blood lead levels as part of required prevention services offered through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. The California Department of Public Health's Childhood Lead Poisoning Prevention Branch (CLPPB) issues guidance for all California providers pursuant to the CCR. The CLPPB sets forth required blood lead standards of care, including Blood Lead and Anticipatory Guidance developed by the Department of Health Care Services (DHCS) related to children enrolled in Medi-Cal. Current CLPPB-issued guidelines include minimum standards of care a network primary care provider (PCP) must follow when conducting blood lead screening tests, interpreting blood lead levels, and determining appropriate follow-up. Blood lead test can be performed using either capillary or venous blood samples, If the result is at or above the Blood Lead Reference Value (BLRV), a confirmatory venous blood test must be obtained.

MCPs must ensure that their network providers (i.e. physicians, nurse practitioners, and physician's assistants) who perform preventive health assessments on child members between the ages of six months to six years (i.e. 72 months) comply with current federal and state laws, and industry guidelines for health care providers issued by CLPPB, including any future updates or amendments to these laws and guidelines.

PCPs are required to do the following:

1. Provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child member that, at a minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age. This anticipatory guidance must be provided to the parent or guardian at each PHA, starting at 6 months of age and continuing until 72 months of age.
2. Order or perform blood lead screening tests on all child members by the required ages and when risks are identified.
3. Report electronically all results to CLPPB when point-of-care blood lead screening tests are performed.
4. Include the CPT code 83655 when submitting claims/encounter data for all point-of-care blood lead tests performed by the PCP office.

PROCEDURE:

1. The PCP will provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child member that, at a minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age.

2. The PCP will order or perform blood lead screening tests on all child members in accordance with the following:

    a. At 12 months and at 24 months of age.
    b. When a child member who is 12 to 24 months of age has no documented evidence of a blood lead screening test taken at 12 months of age or thereafter.
    c. When a child member who is 24 to 72 months of age has no documented evidence of a blood lead screening test taken.
    d. At any time, a change in circumstances have occurred that put the child member at risk.
    e. If requested by the parent or guardian.
    f. Refugees:
        i. Receive an initial screening blood test for lead:
            - Who are 16 years of age or younger
            - Who are older than 16 years of age and at high risk for lead exposure
            - Who are pregnant or lactating
        ii. Receive follow-up blood test 3-6 months after initial test:
            - Who are less than 6 years (72 months) of age, regardless of initial blood lead level
            - Who are ages 7-16 years with an elevated initial blood lead level
            - Who are older than 16 years with risk factors

    The Centers for Disease Control and Prevention (CDC) has recently updated the Blood Lead Reference Level from 5.0 mcdL to 3.5 mcg/dL. Any blood lead test result equal to or greater than 3.5 mcg/dL requires a confirmatory venous blood test within a specified time schedule based on the actual lead test result.

3. The PCP is not required to perform a blood lead screening test if either of the following applies:

    a. If the risk of screening poses a greater risk to the child member's health than the risk of lead poisoning.
    b. If a parent, guardian, or other person with legal authority to withhold consent for the child refuses to consent to the screening.

4. The PCP must document the reason(s) for not performing the blood lead screening test in the child member's medical record. In cases where consent has been withheld, the provider must document this in the child member's medical record by obtaining a signed statement of voluntary refusal.

5. If the provider is unable to obtain a signed statement of voluntary refusal because the party that withheld consent:

    a. refuses or declines to sign it, or
    b. is unable to sign it (e.g., when services are provided via telehealth modality),

The provider must document the reason for not obtaining a signed statement of voluntary refusal in the child's medical record.

6. The PCP performing blood lead analysis must report electronically all results to CLPPB, along with specified patient demographic, ordering physician, and analysis data on each test performed.

RESOURCES:

Standards of Care and Management Guidelines:
https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/CDPH%20Document%20Library/CLPPB-care%20guideline_sources%20of%20lead.pdf
https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/CDPH%20Document%20Library/Lead_HAGs_Table.pdf
https://www.cdc.gov/immigrantrefugeehealth/guidelines/lead-guidelines.html
https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/CDPH%20Document%20Library/BLT_20160426.pdf
https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm
https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/prov.aspx

Reporting blood lead screening test results to CLPPB:
https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/report_results.aspx
http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSCandsectionNum=124130

Anticipatory guidance information for patients in English and Spanish:
https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/CDPH%20Document%20Library/CLPPB-antguid(E)_ADA.pdf
https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/CDPH%20Document%20Library/CLPPB-antguid(S).pdf

DHCS Postcard Resource
https://providers.anthem.com/docs/gpp/CA_CAID_PU_BloodLeadScreening.pdf

SECTION	Approval date:	
Clinical Services	**Approved by:**	
POLICY AND PROCEDURE	**Effective date:**	
Medical and Lab Equipment Maintenance	**Revision date:**	

POLICY:

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

PROCEDURE:

II. MAINTENANCE OF MEDICAL EQUIPMENT

A. Operating manuals for medical and lab equipment shall 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 shall be adopted.

D. Documented proof of servicing shall 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.

III**.** QUALIFIED PERSONNEL

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

ATTACHMENTS: Quality Control Log (sample)

SECTION	Approval date:	
Personnel	Approved by:	
POLICY AND PROCEDURE	Effective date:	
Non-Physician Medical Practitioners	Revision date:	

POLICY:

All primary care provider (PCP) sites that employ non-physician medical providers (NPMP): Nurse Practitioners (NP), Certified Nurse Midwives (CNM), Licensed Midwives (LM), and/or Physician Assistants (PA), shall have standardized procedures (for LMs, NPs and CNM) and/or Practice Agreements/Delegation of Services Agreements (for PAs) that clearly define the scope of services and supervision.

The supervising physician is 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 shall comply with all current and/or revised requirements established by the Medical Board of CA for supervising physician assistants. The supervising physician holds ultimate responsibility for the practice of each supervised non-physician medical practitioner.

PROCEDURE:

I. SCOPE OF PRACTICE OF NON-PHYSICIAN MEDICAL PRACTITIONERS

A. Nurse Practitioners, Certified Nurse Midwives shall have standardized procedures defining their scope of practice and supervision. Standardized procedures legally define the expanded scope of nursing practice that overlaps the practice of medicine. NPs and CNMs operate under written standardized Procedures that are collaboratively developed and approved by the supervising physician, the NP/CNM and administration within the organized health care facility/system in which standardized procedures will be used. 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 and must be dated and signed by the supervising physician and NP/CNM. All Standardized Procedures shall be readily accessible at all practice sites in which the NP or CNM works.

1. 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.
2. 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 shall be credentialed to perform obstetrical care in the same delivering facility in which the CNM has delivery privileges.

B. Physician Assistants shall have Practice Agreements/Delegation of Service Agreements defining their scope of practice and supervision. Practice Agreements/Delegation of Service Agreements 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. Failure to maintain a Practice Agreement/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.

1. Delegation of Service Agreements (DSA): DSAs established prior to January 1, 2020 defines supervision responsibilities and methods required by Title 16, section 1399.545 of the Physician Assistant Regulations. The following procedures are 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; and
    d. Responsibility of the PA to enter the name of approved supervising physician responsible for the patient on the medical record

2. Practice Agreement: According to Senate Bill 697, starting January 1, 2020, newly established Practice Agreements shall define the supervision responsibilities and methods required by the Business and Professions Code, Sections 3502. The Senate Bill 697 removed the required supervisory procedures above under a DSA with the exception of the following: Transport and back-up procedures for when the supervising physician is not on the premises.

C. Standardized Procedures and Practice Agreements/Delegation of Service Agreements shall undergo periodic review every _____ year(s) to identify changes in the NPMP's scope of practice or other information. Standardized Procedures and Practice Agreements/Delegation of Service Agreements shall be revised, dated and signed whenever any changes occur.

D. The supervising physician delegates the supervision of Medical Assistants to NPMPs whenever the supervising physician is off premises.

E. Each NP, CNM, and PA that prescribes controlled substances is required to 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 supervising physician is permitted to supervise the following maximum number of NPMPs at any given time/shift in any of their locations:

- Four (4) Nurse Practitioners with furnishing licenses;
- Four (4) Certified Nurse Midwives; AND
- Four (4) Physician Assistants.

This may bring the total number of NPMPs supervised at any given time/shift/location to 12 (the ratio is unlimited for NPs who do not hold furnishing licenses). 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 shall utilize more NPMPs than can be supervised within these stated limits.

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

C. Evidence of supervision and measure of the NPMP(s) competence are completed using the following process(es) (check all that apply):

- ☐ Peer Review
- ☐ Clinical Competency Assessment
- ☐ Performance evaluation quality appraisal
- ☐ Routine medical record review of NPMPs documentation practice
- ☐ Routine tandem clinic rounds and case reviews
- ☐ Routine review of Standardized Procedures/Practice Agreements/DSA provisions
- ☐ Other (specify): _____

RESOURCES:

https://www.rn.ca.gov/faqs.shtml
https://www.rn.ca.gov/pdfs/regulations/npr-b-03.pdf
https://www.rn.ca.gov/pdfs/regulations/npr-b-20.pdf
https://www.rn.ca.gov/pdfs/regulations/npr-i-25.pdf
https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB697
Notice to Consumers for Physicians and Physician Assistants
Notice to Consumers for Medical Doctors

ATTACHMENT:

Medical Assistant Supervision Delegation Agreement (sample)

SECTION	Approval date:	
Personnel	**Approved by:**	
POLICY AND PROCEDURE	**Effective date:**	
Personnel Training	**Revision date:**	

POLICY:

All staff at PCP sites shall receive 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 at least the specific topics identified below.

PROCEDURE:

I. NEW HIRE TRAINING

A. Upon hire, all new employees shall receive training on safety, members' rights and clinical procedures as outlined in the attached Safety and Member Rights Training Sign-In Sheet.
B. Types of training may include, but are not limited to new employee orientation; in-service training; instructional videos; educational materials; annual group training; self-paced learning modules; etc.
C. Upon completion of each topic within this education/training, the instructor/facilitator shall sign the Provider and Staff Education Checklist with the corresponding date of completion to acknowledge the participant's stated or demonstrated understanding of the education/training provided.
   - When all areas on the Provider and Staff Education Checklist have been completed, the personnel and the instructor/facilitator shall sign and date the Provider and Staff Education Checklist, formally acknowledging the personnel is knowledgeable of all criteria presented by the instructor/facilitator.
   - A copy of the completed Provider and Staff Education Checklist shall be kept in each employee's file. All records or education/training shall be kept for at least three years.

II. ANNUAL REVIEW

A. All personnel shall receive an annual training on at least the following site-specific topics: Infection Control, Blood Borne Pathogens Exposure Prevention and Biohazard Waste Handling.
B. Follow the same procedure as described above for new personnel.

ATTACHMENT: Safety and Member Rights Training Sign-In Sheet – Individuals Format (sample)
Safety and Member Rights Training Sign-In Sheet – Group Format (sample)

SECTION	Approval date:	
Clinical Services	**Approved by:**	
POLICY AND PROCEDURE	**Effective date:**	
Pharmaceutical and Vaccine Services	**Revision date:**	

POLICY:

The site shall maintain competent, efficient, and ethical Pharmaceutical Services according to state and federal statutes for the health and safety of its patients.

PROCEDURE:

I. Drugs and medication supplies are maintained secure to prevent unauthorized access:

A. All drugs (including sample and over the counter), medication supplies, prescription pads, and hazardous substances are securely stored in a lockable space (e.g., a room, closet, cabinet, drawer, etc.) within the office/clinic (CA BandP Code, §4051.3). Keys to the locked storage area are available only to staff authorized by the physician to have access (16 CCR, Chapter, Division 3, §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 prescription pads and hazardous substances must be securely locked.

B. 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, pharmacists and specifically authorized employees) (Control Substance Act, CFR §1301.75). There is no need for the controlled substances to be double locked.
- Controlled Substances include all Schedule I, II, III, IV, and V substances listed in the CA Health and Safety Code, §§11053-11058.

C. A dose-by-dose controlled substance distribution log shall be maintained to include the following:
    a. Date
    b. Provider's DEA number
    c. Name of controlled substance
    d. Original quantity of controlled substance
    e. Dose administered, Number of doses remaining
    f. Name of patient receiving controlled substance
    g. Name of authorized person dispensing controlled substance

II. Drugs are handled safely and stored appropriately.

A. Preparation:
- Drugs are prepared in a clean area, or a "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 §351).

B. 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 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, §211.142). Room temperature where drugs are stored does not exceed 30ºC (86ºF) (Title 22, §75037(d)).

C. 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 2º-8 ºC or 36 º-46 ºF (at time of visit). MMR and varicella are protected from light at all times. Oral polio vaccine (OPV), MMR, MMRV, and varicella vaccines are stored in a freezer maintained at -15 ºC, or 5 ºF, or lower (at time of visit). Failure to adhere to recommended specifications for storage and handling of Immunobiologics could make these products impotent.
- A written plan for vaccine protection in case of power outage or malfunction of the refrigerator or freezer is available on site (see Attachments).
- Site personnel are able to verbalize the procedures in the plan used to promptly respond to out of range temperatures.
- Refrigerator and freezer temperatures are documented at least once a day (required twice daily for VFC providers). CDC recommends use of a continuous temperature monitoring device (data loggers), calibrated at least every 2 years, to monitor vaccine storage unit temperatures. Data loggers should have a minimum accuracy of +/- 1°F (0.5°C), be equipped with buffered probe, an active temperature display outside of the unit, and the capacity for continuous monitoring and recording where the data can be routinely downloaded. A back-up device should be readily available for emergency vaccine transport or when primary data logger is sent in for calibration.

D. 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 residue 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 word, pictures, symbols
  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 (see C.5.).

III. Drugs are administered or dispensed according to State and Federal drug distribution laws and regulations.

A. Drug Dispensing and Administration:

- 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, §4193).
- Criteria for selecting pharmaceutical manufacturers and suppliers shall be established to ensure that patients receive pharmaceuticals and related supplies of the highest quality.
- The clinic shall govern the activities of manufacturers' representatives or vendors of drug products (including related supplies and devices) within the ambulatory care setting. Representatives should not be permitted access to patient care areas and should be provided with guidance on permissible activities. All promotional materials and activities shall be reviewed and approved by the provider.
- Adequate inventory controls shall be maintained to allow proper inventory levels of medications based on utilization.
- A list of drugs available for dispensing shall be maintained (see Attachments).
- Each prescription medication is dispensed in a container that is not cracked, soiled, or without secure closures (Title 22, CCR, §75037 (a)).
- Drugs are dispensed **ONLY** by a physician, pharmacist, or other persons (i.e., NP, CNM, RN, PA) lawfully authorized to dispense medication upon the order of a licensed physician or surgeon. Personnel, such as medical assistants, office managers, and receptionists, **DO NOT DISPENSE DRUGS**.
- A record of all drugs dispensed is entered in the patient's medical record.
- 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, §§ 4170-4171).
- Administration of medications ordered by the licensed practitioner may be completed by the MA using the following procedures:
  a. Prepare medication in a clean area
  b. 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 by:
     - Showing the bottle or vial and medicine cup or syringe to the verifying practitioner
     - Show the patient's chart and original medication order to another verifying practitioner when the ordering practitioner is not available
     - Administer to the patient only after a licensed practitioner has checked the prepared medication for the correct medication, correct dose, correct route, and the appropriate time; and the patient's identity is verified.
  c. To help reduce the risk of medication errors, staff shall confirm the patient's identity prior to administration by asking the patient/parent to confirm the patient's name and date of birth.
  d. Drugs and vaccines are prepared and drawn only prior to administration.
  e. Unused prefilled syringes shall be discarded if not used within the same day that they are filled. Unused syringes that are prefilled by the manufacturer and activated (i.e.,, syringe cap removed or needle attached) shall be discarded at the end of the clinic day.

  NOTE: No MA may administer any anesthetic agent or any medication mixed with an anesthetic agent (e.g., Rocephin diluted with Xylocaine).
- All vaccines administered in the clinic shall be reported by the clinic to an immunization registry (i.e., California Immunization Registry or "CAIR")

B. Vaccine Information Statements (VIS):

- Since 1994, the National Childhood Vaccine Injury Act (§2126 of the Public Health Services 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 ALL vaccines (i.e., DTaP, Td/Tdap, MMR, Influenza, Hepatitis A/B, Pneumococcal, etc.). VIS sheets for all vaccines are available through the CDC website: http://www.cdc.gov/vaccines/pubs/vis/default.htm.

- VIS sheets for distribution to patients are present on site. Site personnel should be able to verbalize standard practices regarding VIS distribution.
- The date the VIS was given and the publication date of the VIS MUST be documented in the patient's medical record. (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) 232-4636. (800-CDC-INFO).

C. Prescription Labeling:

- All stored and dispensed prescription drugs are appropriately labeled with the following:
  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

D. 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.

E. 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 or over the counter (OTC) drugs not bearing the expiration date are deemed to have expired.
- Multi-dose vials (MDV): Per CDC, MDV injectable expire 28 days once opened unless manufacturer recommends a longer or shorter expiration date. Vials must be labeled with date opened. Unlabeled open vials are deemed to have expired.
- Site follows the procedures below to monitor for expiration date and a method of dispose of expired medications/hazardous substances (i.e., sample medications), vaccines, and infant formula. A tracking log is the preferred method of tracking expiration dates (see Attachments).

Type	**Frequency of monitoring:**	**Method of disposal:**
Prescription and OTC drugs / hazardous substances / infant formula	☐ Monthly, ☐ Weekly, or ☐ Other:	
	Frequency of monitoring:	**Method of disposal:**
Vaccines	☐ Monthly, ☐ Weekly, or ☐ Other:	

RESOURCES: Vaccine Information Statements

ATTACHMENTS:
Vaccine Management Plan
Vaccine Emergency Response Worksheet
Vaccine Storage Troubleshooting Record
Temperature Log for Refrigerator and Freezer (Fahrenheit)
Drug Inventory List (sample)
"Where is the VIS Date Located?" Information Sheet
Monthly Potency Verification Log (sample)
Controlled Substances Distribution Log (sample)

SECTION	Approval date:	
Preventive Services	**Approved by:**	
POLICY AND PROCEDURE	**Effective date:**	
Preventive Care Screening Equipment	**Revision 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:

I. The following equipment shall be maintained on site 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 patients contact. The exam table is in "good repair" (i.e., is clean, well maintained, and in proper working order).

B. Scales:
- Infant scales are marked and accurate to increments of one (1) ounce or less, and have a capacity of at least 35 pounds. Infants and children are weighed undressed or wearing indoor minimal clothing. If the child resists to the extent that s/he 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 are accurate to increments of one-fourth (¼) pound or less with a capacity of at least 300.
- 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 90º 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 or 1mm) or less. The "0" of the tape is exactly as the base of the headboard for recumbent measurement, or exactly at foot level for standing measurement.
- Non-flexible footboard at 90º right angle perpendicular to the recumbent measurement surface or 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 or 1mm) 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., small, regular, extra large/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:
- Members who are 3 to 20 years old and are seen for pediatric preventive services shall have a visual acuity screening using eye charts recommended by the American Academy of Pediatrics (AAP). Both literate (e.g., Sloan or Snellen) and illiterate (e.g., HOTV or LEA) eye charts are available.
- Wall mounted eye charts are height adjustable and positioned at the eye-level of the patient.
- Arch line(s) are clearly established and aligned with the center of the eye chart at a distance of 10 or 20 feet depending on the 10-foot or 20-foot vision chart used. Examiners shall stand their patients with the arch of their feet to the line unless the eye chart that is being used to screen specifically instructs the patient to be positioned elsewhere.
- Eye charts are located in an area with adequate lighting and at height appropriate to patient (adjustable).
- Effective occlusion, such as with tape or an occlusive patch of the eye not being tested, is important to eliminate the possibility of peeking. If patch is not available or tolerated, acceptable occluders include specially designed occlusion glasses and for children 10 years and older, an occlusive paddle with a hole for the child to look through.
- For infection control purposes, disposable occlusive devices are preferred because they minimize the risk of transmitting infection between patients. If reusable occluders are utilized, site shall disinfect them appropriately between patients.

Please visit the AAP link for more detailed requirements:
https://pediatrics.aappublications.org/content/137/1/e20153597

F. Audiometric Testing:
- Members who are 4 to 20 years old and are seen for pediatric preventive services shall have an audiometric screening with a pure tone, air conduction audiometer available. Members that are referred to another provider for audiometric testing shall have a copy of their test results/report available in the member's medical record for review.
- The pure tone audiometer shall have the minimum ability to:
  a. Produce intensities between 0 to 90 dB;
  b. Have a headset with right and left earphones;
  c. Be operated manually; and
  d. Produce frequencies at 500, 1000, 2000, 3000, 4000, 6000, and 8000 Hz.

Please visit the following links for more detailed requirements:
https://publications.aap.org/pediatrics/article/152/3/e2023063288/193755/Hearing-Assessment-in-Infants-Children-and

RESOURCES:
https://www.aap.org/en/practice-management/care-delivery-approaches/periodicity-schedule/

ATTACHMENTS: Medical Assistant Certification (sample)
Well Child Screening – Staff Competency Checklist

SECTION	Approval date:	
Clinical Services	Approved by:	
POLICY AND PROCEDURE	Effective date:	
Radiology Services	Revision date:	

POLICY:

The site shall meet California Department of Public Health (CDPH) Radiological Health Branch (RHB) inspection and safety regulations by ensuring that radiation is used safely and effectively, individuals are protected from unnecessary 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). The Radiologic Health Branch of the Food, Drug, and Radiation Safety Division of the CDPH 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.

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.

PROCEDURE:

I. Site has current CA Radiologic Health Branch (RHB) Inspection Report and Proof of Registration for any radiological equipment on site. Proof of Registration shall be determined by using the CDPH/RHB website: https://regsearchtool.cdph.ca.gov/rhb-facility-search (search by Facility Registration Number, Name, or Machine Address).

   A. The site shall have current documentation of one of the following:
      - Inspection Report and Proof of Registration, or
      - Inspection Report and Proof of Registration and Short Form Sign-off sheet, or
      - Inspection Report, Proof of Registration and Notice of Violation form and approval letter for corrective action plan from the CA RHB.

   B. Equipment inspection, based on a “priority” rating system, is established by legislation (CA HandS Code, Section 115115)
      - Mammography equipment is inspected annually (Mammography 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
      - Site personnel shall contact the Radiological Health Branch at (916) 327-5106 for more information on the “current” status of equipment inspection.

II. The following documents shall be posted on site:

A. Current copy of Title 17 with a posted notice about availability of Title 17 and its location.
B. “Radiation Safety Operating Procedures” posted in a highly visible location.
C. “Notice to Employees Poster” posted in a highly visible location.
D. “Caution, X-ray” sign posted on or next to door of each room that has X-ray equipment
E. Physician Supervision/Operator certificate posted and within current expiration date
F. Technologist certificate shall be maintained current posted on site
    - 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.

III. The following radiological protective equipment shall be present on site, unless only dexascanners are present:

A. Operator protection devices: radiologic equipment operator shall use lead apron or lead shield
B. Gonadal shield (0.5 mm or greater lead equivalent): for patient procedures in which gonads are in direct beam

NOTE:

For questions regarding radiologic safety (e.g., expired or missing inspection documentation on site), call CDPH Radiological Health Branch (Compliance Unit) at (916) 327-5106. For Radiation Emergency Assistance, call 1-800-852-7550.

RESOURCES:

https://www.cdph.ca.gov/Programs/CEH/DRSEM/Pages/RHB-LawsAndRegs.aspx#
Title 17

SECTION	Approval date:	
Personnel	Approved by:	
POLICY AND PROCEDURE	Effective date:	
Staff Qualifications	Revision date:	

POLICY:

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

PROCEDURE:

I. HEALTH CARE LICENSE AND CERTIFICATION REQUIREMENTS

A. All medical professional licenses and certifications are current and issued from the appropriate agency to practice in California. Copies and/or lists of currently certified or credentialed personnel shall 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 and Surgeon's Certificate, DEA Registration	Osteopathic Medical Board of CA, Drug Enforcement Administration
Licensed Midwife (LM)	Midwifery License Drug Enforcement Agency (DEA) Registration, *if appropriate*	Medical Board of CA DEA
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 Registration Nursing
Pharmacist (Pharm.D)	Pharmacist License	CA State Board of Pharmacy
Physician/Surgeon (MD)	Physician's and 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 Dietician (RD)	RD Registration Card	Commission on Dietetic Registration
Registered Nurse (RN)	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 (RN) or licensed vocational nurse (LVN).

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 shall be able to demonstrate operation of medical equipment used in their scope of work.

SECTION	Approval date:	
Office Management	Approved by:	
POLICY AND PROCEDURE	**Effective date:**	
Triage	**Revision 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 shall ensure that appropriate personnel handle emergent, urgent and medical advice telephone calls. This includes licensed medical personnel such as a Certified Nurse Mid-Wives, Nurse Practitioners, Registered Nurses or Physician Assistants. Licensed Vocational Nurses (LVN) shall not perform triage independently (MCPB letter 92-15). 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)).

B. Staff shall ensure that a telephone answering machine, voice mail system or answering service is utilized whenever office staff does not directly answer phone calls.
   1. The providers are responsible for the answering service they utilize. If a member calls after hours or on weekends due to possible medical emergency, the practitioner is responsible for authorization of or referral to, emergency care given by the answering service. There shall be a greeting that immediately state the following or similar instruction to the member: "If this is a life-threatening emergency, hang up and call 911 or go to the nearest emergency room."
   2. 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.
   3. Unlicensed personnel responsible for answering telephone calls shall have clear instructions on parameters related to the appropriate questions to ask and responses to give to members in order to assist a licensed provider in triaging the member for appropriate care.

C. Staff shall ensure that the telephone system, answering service, recorded telephone information, and recording devices are periodically checked and updated (see *Access to Care 24/7 Policy* for periodic monitoring schedule). The Health Plan encourage answering services to follow these steps when receiving a call:

1. 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.
2. Ask the member according to the PCP's or Physician Group's established instructions (who, what, when, and where) to assess the nature and extent of the problem.
3. Contact the on-call physician with the facts as stated by the member.
4. 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.

SECTION	Approval date:	
Personnel	Approved by:	
POLICY AND PROCEDURE	Effective date:	
Unlicensed Personnel	Revision date:	

POLICY:

All professional health care personnel shall 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 in the treatment facility during the performance of authorized procedures by the MA.

B. To administer medications by subcutaneous or intramuscular injection, or to perform intradermal skin tests, or venipunctures for withdrawing blood, an MA shall have completed at least the minimum number of training hours established in CCR, Title 16, Section 1366.1.

C. Training shall 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 shall be maintained on-site and include the following:

1. Diploma or certification from an accredited training program/school, or
2. 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. MEDICATION ADMINISTRATION

A. Unlicensed staff shall have evidence of appropriate training and supervision in all medication administration methods performed within their scope of work.

- The supervising physician shall specifically authorize all medications administered by an MA by means of a specific written or standing order prepared by the supervising physician.
- Medication administration by an 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 shall be shown to the licensed person prior to withdrawal of the medication from the container and administration.
- 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.

III. MEDICAL EQUIPMENT

A. Personnel on site shall be qualified for their responsibilities and adequately trained for their scope of work. Site staff shall 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 shall be able to demonstrate operation of medical equipment used in their scope of work.

IV. IDENTIFICATION OF HEALTH CARE PRACTITIONERS

A. A health care practitioner shall disclose his or her name and the 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 (RN) or licensed vocational nurse (LVN).

ATTACHMENTS: Medical Assistant Certification (sample)
Venipuncture, Injection and Skin Puncture Certification (sample)
Medical Assistant Supervision Delegation Agreement (sample)
Well Child Screening – Staff Competency Checklist