FACILITY SITE REVIEW (FSR) GUIDE
https://www.providerservices.iehp.org/en/resources/resources-for-providers/site-review-resources

Access Safety Standards			
Criteria	**Highlights (Refer to page in standards for details)**	**Page in Standards**	**Other Resources**
☐ Site is accessible and useable by individuals with physical disabilities.	• Clearly marked disabled-parking space near accessible main entrance. • Elevators are accessible and ramps are level at the top and bottom, as applicable. • Doorway openings are at least 32 inches wide when fully opened. • Clear floor space for wheelchairs in waiting area and exam rooms. • Wheelchair accessible restrooms and handwashing facilities.	3 – 5	
☐ Site environment is clean and safe for all patients, visitors and personnel.	• All patient areas and restrooms are clean and with enough sanitary supplies. Exam table covers are not ripped. • Evidence that staff has received safety training and has safety information available on the following: ✓ Fire safety and prevention. ✓ Emergency non-medical procedures. • Staff must know where to locate and use the written site protocol for emergencies. • Lighting is adequate in all areas. Electrical cords and outlets are in good working condition. • Exit doors, aisles, and hallways are unobstructed. Exit signs and evacuation route maps are visibly posted. • At least one of the following fire safety equipment is on site and accessible: ✓ Fire Extinguisher (with updated evidence of inspection) ✓ Smoke Detector with intact batteries ✓ Automatic Sprinkler System • An employee alarm system. ✓ 10 or fewer employees, including providers – direct voice communication and code word/s ✓ >10 employees, including providers – operable alarm system with distinctive signal	6 – 8	• Medical, Non-Medical Emergency Protocols 8 – 9
☐ Emergency healthcare services are available and accessible 24 hours a day, 7 days a week.	• Staff can describe procedures for handling medical emergencies. MAs must not leave patient alone. • Emergency phone number contacts are posted, updated annually and as changes occur. • Emergency equipment are easily accessible and ideally stored in the same location. ✓ Oxygen tank must be at least 3/4 full and MA can demonstrate how to operate. ✓ Nasal cannula or mask, bulb syringe, and Ambu bag are available in different sizes, based on site population. ✓ Emergency medications must be available onsite and not expired: - Epinephrine 1mg/mL (injectable) - Diphenhydramine 25 mg (oral) OR 50 mg/ml (injectable) - Naloxone - Chewable aspirin 81 mg - Nitroglycerin spray/tablet – If site sees patients 18+ - Glucose – at least 15 grams - Bronchodilator medication – nebulizer solution (must have nebulizer) or metered dose inhaler - Appropriate sizes of ESIP needles/syringes and alcohol wipes • Med dosage chart for all meds in the emergency kit, including additional meds. Copy of chart in the emergency kit. • Log or checklist showing that emergency equipment/supplies are checked at least monthly. • Replace/re-stock emergency medication, equipment, and supplies immediately after use.	9 – 13	• Medical, Non-Medical Emergency Protocols 8 – 9 • Pre-filled Emergency Medications Dosage Chart 10 – 12 • Monthly Expiration Date & Verification Log 13
☐ Medical and lab equipment used for patient care is properly maintained.	• Medical equipment is clean and has evidence of routine inspection/calibration. • Calibration of audiometer must show it was assessed using ANSI standards.	13 – 14	• Sample ANSI Calibration 14 – 18

Personnel Standards			
Criteria	**Highlights** **(Refer to page in standards for details)**	**Page in Standards**	**Other Resources**
☐ Professional health care personnel have current California licenses and certifications.	• Provide a copy of the staff's current license and DEA (if appropriate): MD, DO, NP, PA, RN, LVN, CRT, RD.	15 – 16	
☐ All required professional licenses and certifications, issued from the appropriate licensing/ certification agency, are current.	• Notification is provided to each member that the MD(s) is licensed and regulated by the Medical Board, and that the PA(s) is licensed and regulated by the Physician Assistant Board. Choose of the following methods: ✓ Prominently posted sign that includes a QR code in an area visible to patients in at least 48-pt Arial font. ✓ A written statement signed and dated by the patient (or patient's representative) and kept in the medical record. ✓ A statement on letterhead, discharge instructions or other document given to the patient (or patient's representative), where the notification is placed immediately above the signature line for the patient in at least 14-pt font.	16 – 17	• Notice to Consumer - MD English 19 • Notice to Consumer - MD Spanish 20 • Notice to Consumer PA Sign - English 21 • Notice to Consumer PA Sign - Spanish 22 • Notice to Consumer DO Sign - English 23 • Notice to Consumer NP Sign - English 24
☐ Health care personnel are properly identified.	• Health care personnel wear identification badges/tags printed with name and title.		
☐ Site personnel are qualified and trained for assigned responsibilities.	• Required education/training for non-licensed medical personnel (MAs): ✓ MA certificate OR signed MA Letter of Competency ✓ Midlevel Supervision of MA, if applicable ✓ For sites with pediatric patients (under 21 years), evidence of completed training in: - Audiometric screening - Vision screening - Anthropometric measurements, including obtaining Body Mass Index (BMI) - Dental screening and fluoride varnish application • All medications administered by MAs, including vaccines, must be verified with (shown to) a licensed person prior to administration. • MA must demonstrate that site has a process for confirming the right patient, right medication/vaccine, right dose, and right route prior to administration. • MAs cannot administer anesthetics, including local anesthetic agents.	17 – 20	• Medical Assistant Letter of Competency - Fillable 25-26 • Mid-level Supervision of Medical Assistant 27 • Medication Administration Procedures 28
☐ Scope of practice for non-physician medical practitioners (NPMP) is clearly defined.	• Standardized Procedures for NPs and/or CNMs and Practice Agreement for PAs. • Must defines the scope of services and the method of supervision by the Supervising Physician. • Must be reviewed, revised, updated, and signed by the supervising physician and NPMP annually or when changes in scope of services occur.	20 – 23	• Standardized Procedures for Nurse Practitioner 29 – 43 • Physician Associate Practice Agreement Sample 44 – 47
☐ NPMP are supervised according to established standards.	• Maximum of 4 NPMP (NP with furnishing license, CNM, PA) to be supervised by 1 PCP. • No limit to number of NPs the physician may supervise if the NP does not hold a furnishing license. • The designated supervising or back-up physician is always available in person or by electronic communication when an NPMP is caring for patients.	23 – 24	

☐ Site personnel receive safety training.	• There is evidence that site staff, including providers, has received annual training on the following. Site must also have a site policy for each topic. ✓ Infection Control/Universal Precautions ✓ Bloodborne Pathogens Exposure Prevention ✓ Biohazardous Waste Handling • There is evidence that site staff, including providers, has received training on the following. Site must also have a site policy for each topic. ✓ Patient Confidentiality ✓ Informed Consent, including Human Sterilization ✓ Prior Authorization Requests ✓ Grievance/Complaint Procedure ✓ Child/Elder/Domestic Violence Abuse ✓ Sensitive Services/Minors' Rights ✓ Health Plan Referral Process ✓ Cultural and Linguistic Training ✓ Disability Rights and Provider Obligations	24 – 28	• IEHP Evidence of Staff Training 48 • Online Resources for Required Employee Training 49 • Infection Control, Biohazardous Waste and Disposition of Patients with Contagious Disease 50 – 53 • Bloodborne Pathogens & Post Exposure Plan - Fillable 54 – 63 • Confidentiality Form 64 • IEHP Grievance Resolution Process - English 65 – 72 • IEHP P&P Child Abuse Reporting 73 – 76 • Domestic Violence 77 • IEHP P&P Elder or Adult Abuse Reporting 78 – 84 • IEHP P&P Sensitive Services-Access Standards 85 – 87 • IEHP Cultural and Linguistics Training 88 – 109 • Referral Process 110 – 111
Office Management Standards			
Criteria	**Highlights (Refer to page in standards for details)**	**Page in Standards**	**Other Resources**
☐ Physician coverage is available 24/7.	• Clinic office hours are posted or readily available upon request. • Provider schedules and contact information for off-site physician(s) are available to staff. • Schedule for after-hours, on-call, and supervisory back-up physician coverage is available to site staff and members after-hours. • After-hours phone message must include emergency care instructions. Auditor must be able to reach the on-call provider or nurse.	29	• After Hour Script 112 • On-Call Provider Schedule and Contact Numbers 113
☐ There are sufficient health care personnel to provide timely, appropriate healthcare services.	• Only appropriately licensed medical personnel (MD, DO, NP, PA, RN) handles emergency, urgent, and medical advice/triage telephone calls. • Telephone answering machine, voice mail system, or answering service is used whenever office staff does not directly answer phone calls. These systems must be periodically checked for messages and updated as needed.	29 – 30	
☐ Health care services are readily available.	• Appointments are scheduled within the timeliness standards: ✓ Urgent Visits: 48 hours ✓ Non-Urgent/Routine Visits: 10 business days ✓ First Prenatal Visit: 10 business days • Patients are notified of scheduled routine and/or preventive screening appointments. • There is a process for follow-up on missed, rescheduled, canceled, and no-show appointments.	30 – 31	• Access Standards 114 – 126
☐ There is 24-hour access to interpreter services.	• Interpreter services are made available in identified threshold languages specified for location of site. If using IEHP interpreter line, staff must know where to access the telephone number. • Persons providing language interpreter services, including sign language on site, are trained in medical interpretation.	31 – 32	• Standards of Interpreter Services Provider Process 127 – 130
☐ Procedures for timely referral/ consultative services are established on site.	• Site staff responsible for referrals can verbally explain the office referral process from beginning to end (from provider order to review of consult note/test result, or to follow-up if no consult note/test result received). • Show the referral log/system used to keep track of referrals. • Physician Review and follow-up of referral/consultation reports and diagnostic test results.	32 – 33	• Referral Process 110 – 111 • PCP Referral Tracking Log 131

☐ Member grievance/ complaint processes are established on site.	• Staff must know at least one telephone number for filing grievances. It is posted on site or is readily available upon request. • Complaint forms and a copy of the grievance procedure are available on site.	33	
☐ Medical records are available for the provider at each scheduled patient encounter.	• Medical records (paper and electronic) are available, including outpatient, inpatient, referral services, and significant telephone consultations for patient encounters. • Medical documents are filed in a timely manner to ensure availability for patient encounters.	33 – 34	
☐ Confidentiality of personal medical information is protected according to State and federal guidelines.	• Exam rooms/dressing areas safeguard patients' right to privacy. • Procedures are followed to maintain the confidentiality of personal patient information. • Individual patient information is not discussed/displayed in front of other patients or visitors. This includes unattended electronic devices and patient registration sign-in sheets. • There must be a confidentiality agreement between the provider and the cleaning service agency/persons if the medical records are kept in an open space and/or are unsecured. • Medical record release procedures must include the expiration date of the consent. • Fax cover sheet shall have confidentiality statement. • Medical records are retained for a minimum of 10 years.	34 – 37	• Fax Cover Sheet 132 • Medical Record Release 133

Clinical Services: Pharmaceutical Standards

Criteria	Highlights (Refer to page in standards for details)	Page in Standards	Other Resources
☐ Drugs and medication supplies are maintained secured to prevent unauthorized access.	• Drugs are stored in specifically designated cupboards, cabinets, closets or drawers. • Drugs, needles/syringes, all medical sharp instruments, hazardous substances and prescription pads are securely stored in a lockable space (cabinet or room) within the office/clinic. • Controlled substances are stored separately from other drugs in a securely locked, substantially constructed cabinet accessible only to authorized personnel. • A dose-by-dose controlled substance distribution log is maintained. • Written site-specific policy/procedure for dispensing of sample drugs are available on site.	37 – 39	• Patient Distribution Log for Samples 134 • Controlled Substance Distribution Log 135 • P&P Distribution of Sample Medications 136 – 137
☐ Drugs are handled safely and stored appropriately.	• Drugs are prepared in a clean area or "designated clean" area if prepared in a multi-purpose room. • Drugs for external use are stored separately from drugs for internal use. • Drugs and vaccines are stored separately from test reagents, germicides, disinfectants, and other household substances. • Hazardous substances are appropriately labeled. Secondary containers must have a label with the following: ▪ Identity of hazardous substance ▪ Description of hazard warning: can be words, pictures, symbols ▪ Date of preparation or transfer ▪ Expiration date • Refrigerator and/or freezer for drugs/vaccine can maintain required temperature (not dorm-style). ▪ Refrigerator thermometer temperature is 36º-46º Fahrenheit or 2º-8º Centigrade (at time of site visit). ▪ Freezer thermometer temperature is 5º Fahrenheit or –15º Centigrade, or lower (at time of site visit). ▪ Items other than medications in refrigerator/freezer are kept in a secured, separate compartment from drugs. ▪ Daily temperature readings of drugs/vaccines refrigerator and freezer are documented. Temperature records must be kept for at least 3 years. ▪ Has a written plan for vaccine protection in case of power outage or malfunction of the refrigerator or freezer. Must be posted on or near the refrigerator and/or freezer.	39 – 44	• Clean and Dirty Sign 138 • Refrigerator Temperature Log 139 – 140 • Plan for Vaccine Protection in Case of Power Outage 141 • Vaccine Storage and VIS 142

☐ Drugs are dispensed according to State and federal drug distribution laws and regulations.	• There are no expired drugs on site. • If a multi-dose has been opened or accessed (needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. • Site has a procedure to check expiration date of all drugs (including vaccines and samples), and infant and therapeutic formulas. • All stored and dispensed prescription drugs are appropriately labeled. • Only lawfully authorized persons dispense drugs to patients. • Drugs and Vaccines are prepared and drawn only prior to administration. • Current Vaccine Information Sheets (VIS) for distribution to patients are present on site. • If there is a pharmacy on site, it is licensed by the CA State Board of Pharmacy. • Site utilizes California Immunization Registry (CAIR) or the most current version. Site can demonstrate this by logging into the CAIR website during the audit or showing how CAIR is connected to their EMR.	44 – 49	• Monthly Expiration Date & Verification Log 13
Clinical Services: Laboratory Review Standards			
Criteria	**Highlights (Refer to page in standards for details)**	**Page in Standards**	**Other Resources**
☐ Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations.	• Site must have a current site-specific CLIA certificate. • Personnel performing clinical lab procedures have been trained. • Lab supplies (e.g. vacutainers, vacutainer tubes, culture swabs, test solutions) are in accessible to unauthorized persons. • Lab test supplies are not expired. • Site has a procedure to check expiration date and a method to dispose of expired lab test supplies. • Site must keep records of controls performed, such as for hemocue and glucometer.	50 – 52	• Glucometer Log 143 • Hemocue Log 144
Clinical Services: Radiology Review Standards			
Criteria	**Highlights (Refer to page in standards for details)**	**Page in Standards**	**Other Resources**
☐ Site meets CDPH Radiological inspection and safety regulations.	• Site has current CA Radiologic Health Branch Inspection Report and Proof of Registration if there is radiological equipment on site. • The following documents are posted on site: ▪ Current copy of Title 17 with a posted notice about availability of Title 17 and its location. ▪ "Radiation Safety Operating Procedures" posted in highly visible location. ▪ "Notice to Employees Poster" posted in highly visible location. ▪ "Caution, X-ray" sign posted on or next to door of each room that has X-ray equipment. ▪ Physician Supervisor/Operator certificate posted and within current expiration date. ▪ Technologist certificate posted and within current expiration date. • The following radiological protective equipment is present on site: ▪ Operator protection devices: radiological equipment operator must use lead apron or lead shield. ▪ Gonadal shield (0.5 mm or greater lead equivalent) for patient procedures in which gonads are in direct beam. • Radiological Equipment must be inspected within the established frequency: ▪ Mammography equipment is inspected annually, must have federal FDA Certification onsite, 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 uses, and likelihood of radiation exposure.	53 – 55	• Radiology Inspection Report Sample 145 • Radiology - Notice to Employees 146

Preventive Services Standards			
Criteria	**Highlights (Refer to page in standards for details)**	**Page in Standards**	**Other Resources**
☐ Preventive healthcare services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases.	• Examination equipment, appropriate for primary care services, is available on site: ▪ Exam tables and lights are in good repair. ▪ Stethoscope and sphygmomanometer with various size cuffs (e.g. child, adult, obese OR thigh). ▪ Thermometer with a numeric reading. ▪ Percussion hammer. ▪ Tongue blades. ▪ Patient gowns. ▪ Standing balance beam (at least 300 lb capacity, not a bathroom scale) and infant scales. ▪ Measuring devices for stature (height/length, must have rigid headboard block) and head circumference (non-stretchable tape measure). ▪ Eye charts (literate and illiterate) and opaque occluder for vision testing. - Literate charts: Snellen. - Illiterate charts: LEA or HOTV. - Wall mounted eye charts are height adjustable and positioned at the eye-level of the patient. - Heel lines are 10 or 20-feet away, depending on chart used. - For sites with pediatric patients: must have pediatric occluder (ex. glasses, occlusive eye patch). ▪ Ophthalmoscope. ▪ Otoscope with adult and pediatric ear speculums. ▪ Pure tone, air conduction audiometer is in a quiet location for testing. Must have the minimum ability to: - Produce intensities between 0 to 80 dB. - Have a headset with right and left earphones. - Be operated manually. - Produce frequencies at 1000, 2000, 3000, 4000, 6000, and 8000 Hz.	56 – 59	• Sample Eye Charts 147 • Visual Acuity Screen Tips 148 • Pure Tone Audiometer 149
☐ Health education services are available to Plan members.	• Health education materials and plan-specific resource information are: ▪ Readily accessible on site or are made available upon request. ▪ Applicable to the practice and population served on site. ▪ Available in threshold languages identified for county and/or area of site location. ▪ Should include general topics for health educational material such as: Immunizations, Pregnancy, Injury Prevention, Smoking Cessation, Dental Health, Nutrition, Physical Activity, STD/HIV Prevention, Family Planning, Asthma, Hypertension, and Diabetes. ▪ Must meet the Medi-Cal Managed Care readability and suitability requirements for educational material distributed to Medi-Cal members.	59 – 60	

Infection Control Standards			
Criteria	**Highlights (Refer to page in standards for details)**	**Page in Standards**	**Other Resources**
☐ Infection control procedures for Standard/Universal precautions are followed.	• Hand washing facilities are available in the exam room (water, soap, paper towels OR hand sanitizer). • A waste disposal container is available in exam rooms, procedure/treatment rooms, and restrooms. • Site has procedure for effectively isolating infectious patients with potential communicable conditions.	61 – 62	

☐ Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act.	• PPE must be readily available. ▪ Gloves ▪ Water repellent clothing barrier/gown ▪ Goggles or face shield ▪ Face mask • Biohazardous and Regulated Wastes are placed in appropriate leak proof, labeled containers. • Needlestick safety precautions are practiced on site. ▪ Sharps containers are located close to the immediate area where sharps are used and are inaccessible to unauthorized persons. They are not overfilled or more than 3/4 full. ▪ All sharp injury incidents are documented. • Storage areas for regulated medical waste are maintained secure and inaccessible to unauthorized persons. ▪ Regulated waste is contained separately from other wastes and placed in red biohazardous bags with Biohazard label and stored in a closed container that is not accessible to unauthorized persons. ▪ If stored outside the office: a lock secures the entry door, gate or receptacle lid, and posted warning sign(s) in English and Spanish are visible for 25-feet. • Contaminated laundry is laundered at the workplace or by a commercial laundry service. • Evidence (ex. receipts, service agreement) of transportation of regulated medical wastes is only by a registered hazardous waste hauler or to a central location of accumulation in limited quantities (up to 35.2 pounds).	63 – 68	• P&P Transport for Reusable Instruments 150 • Medical Waste Programs 151 • Safety Needle Fact Sheet 152 – 153 • Transfer Stations and Treatment Facilities 154 - 158 • Sharps Injury Log Sample 159
☐ Contaminated surfaces are decontaminated according to Cal-OSHA standards.	• Written “housekeeping” schedules have been established and are followed for regular routine daily cleaning. • Disinfectant solutions used on site are: ▪ Approved by the Environmental Protection Agency (EPA). ▪ Effective in killing HIV/HBV/TB. ▪ Follow manufacturer instructions. Staff must know "kill time" of solution. • If using 10% bleach solution: ▪ 10% bleach solution that is EPA registered, effective against TB, and is changed/reconstituted every 24 hours. ▪ Surface is cleaned prior to disinfecting. ▪ Surface is air-dried or allowed appropriate time (stated on label) before drying. ▪ Manufacturer’s directions, specific to every bleach product, are followed carefully.	68 – 70	• Cleaning Schedule 160
☐ Reusable medical instruments are properly sterilized after each use.	• Written site-specific procedures or manufacturer’s instructions for instrument sterilization are available to staff. • Cleaning reusable instruments prior to sterilization using enzymatic detergent, rinsed, dried, and inspected for the presence of dried blood or other debris. • Cold chemical sterilization/high level disinfection: ▪ Staff must demonstrate/verbalize the necessary steps to ensure sterility and/or high-level disinfection of equipment. ▪ Confirmation from manufacturer item(s) is/are heat sensitive. ▪ The following are available: appropriate PPE, exposure control plan, Material Safety Data Sheets (MSDS), and clean up instructions in the event of a cold chemical sterilant spill. • Autoclave/Steam Sterilization: ▪ Staff demonstrate/verbalize necessary steps to ensure sterility. ▪ Autoclave is maintained and serviced according to manufacturers’ guidelines. Documentation of maintenance should include: - Mechanical problems. - Inspection dates. - Results/outcome of routine servicing. - Calibration. - Repairs, etc. • Spore testing of autoclave/steam sterilizer with documented results (at least monthly). • Management of positive mechanical, chemical, and biological indicators of the sterilization process: staff must verbalize how to manage positive spore tests (5 R’s: Run, Remove, Retrieve, Record, Respond). • Sterilized packages are labeled appropriately with the following information: ▪ Date of sterilization. ▪ Load run identification information. ▪ Initials of staff member. ▪ Description of general contents (e.g. suture set). ▪ Storage areas for sterilized packages are clean, dry and separated from non-sterile items by a functional barrier (e.g., shelf, cabinet door, and drawer).	70 – 77	• P&P Autoclave 161 • P&P Autoclaving Instruments in Peel Pack Pouches 162 • Autoclave Log 163 • P&P Chemical Disinfection 164 • P&P Spore Testing 165 • P&P Transport for Reusable Instruments 166

Office Emergency Protocol

In Case of an Emergency

Front office: Call 911 or ambulance (as directed by Doctor)

Medical Assistant: Stay with the patient. Give medications as directed by Doctor.

Back Office: Bring emergency kit/equipment i.e. Oxygen
Bring supplies requested by Doctor
Keep a written record of all medication (with time) given to patient.

Doctor: Stay with the patient.

During a Fire

- In case of fire, evacuate the immediate area.
- Notify all persons in the area to evacuate the building.
- Make sure that you assist your patients out of the building. Elderly clients and young children may need assistance with the stairs.
- Do not re-enter the building unless the all clear signal is given. If needed, fire extinguishers are available.

Earthquake

DURING AN EARTHQUAKE

- Stay in the building. Do not evacuate.
- Assist any disabled persons in the area and find a safe place for them.
- DROP, and take shelter under tables, desks, in doorways and similar places. Keep away from overhead fixtures, windows, filing cabinets and bookcases. COVER your head and neck with your arms. HOLD the position until the ground stops shaking.
- If you're outside, stay outside. Move to an open to an open area away from buildings, tree, power lines, and roadways.

AFTER AN EARTHQUAKE

- Check for injuries. If qualified, give first aid, otherwise, seek help.
- Check for safety hazards: fire, electrical, gas leaks, water supply, etc. Coordinate with your supervisor and begin turning off all potentially hazardous equipment such as gas and electric appliances.
- Do not use telephones, including cellular/mobile phones, or roads unless necessary. Keep them open for emergency use.
- Be prepared for aftershocks
- Cooperate, keep informed and remain clam.
- DO NOT RETURN to the building unless told to do so by Police, Fire Department, or authorized personnel.

IF EVACUATION IS ORDERED:

- Seek out any disabled or injured persons in the area and give assistance. Exit using the stairway. Do not use elevators.
- Beware of falling debris or electrical wires as you exit.
- Go to an open area way from buildings, trees, powerlines and roadways. Wait for instructions.

Employee Alert Protocol

_____

_____

_____

_____

_____

_____

Location of Emergency Kit: _____

Location of Oxygen Tank: _____

Updated: _____

SAMPLE

EMERGENCY NUMBERS

Emergency: _____
Local Ambulance: _____
Local Police: _____
Local Fire Department: _____

ADDITIONAL NUMBERS

Poison Control: 1-800-876-4766
Child Abuse Hotline: 1-800-827-8724

Elder Abuse Hotline: 1-877-565-2020
National Domestic Abuse Hotline: 1-800-799-7233
Suicide Hotline: 1-800-273-8255

GRIEVANCE & APPEALS INFORMATION/NUMBERS

IEHP (Inland Empire Health Plan)
10801 Sixth Street, Suite 120
Rancho Cucamonga, CA 91730
Email: MemberServices@iehp.org

Telephone: 1-800-440-4347
TTY: 1-800-718-4347
FAX: 1-909-890-5748

For more assistance:
DMHC Help Center: 1-888-466-2219
Ombudsman: 1-888-452-8609

Interpreter Services

Hours: 8:00 am to 5:00pm
Call Member Services: 1-800-440-4347

After Hours Call:
Call Nurse Advice Line: 1-888-244-4347

Covering Provider

Provider: _____ **Phone:** _____

Office Manager

Office Manager's Name: _____
Phone Number: _____

Updated: _____

SAMPLE

SAMPLE _Emergency medications dosage chart _SAMPLE

This document is for informational purposes and may be used and/or modified according to site specific practices. All medications (required or optional) in the emergency kit shall be included in the dosage chart. The Clinic Provider shall review and approve all contents in this document prior to adoption.

*** Please confirm all dosages with the manufacturer for all medications administered on site***

Rx name	Adults	Pediatrics
Albuterol sulfate* Inhalation solution (0.0836% - 2.5 mg/ 3 ml)	2.5mg to 5mg every 20 minutes for 3 doses, then 2.5 mg to 10 mg every 1 to 4 hours PRN	**Children:** 2.5 mg to 5 mg every 20 minutes for 3 doses, then 2.5 mg to 10 mg every 1 to 4 hours PRN. **Infants & Neonates:** 2.5 mg every 20 minutes for the first hour PRN; if there is rapid response, can change to every 3 to 4 hours PRN.
Inhalation aerosol metered dose (90 mcg/actuation)	4 to 8 inhalations every 20 minutes for up to 4 hours, then 1 to 4 hours PRN	**Children:** 2 to 10 inhalations every 20 minutes for 2 to 3 doses; if rapid response, can change to every 3 to 4 hours PRN. **Infants & Neonates:** 2 to 6 inhalations every 20 minutes for 2 to 3 doses; if there is rapid response, can change to every 3 to 4 hours PRN.
Aspirin* Chewable tablet 81 mg (not enteric coated)	**For myocardial infarction (MI)**: Chew 2 to 4 tablets upon presentation or within 48 hours of stroke	**For myocardial infarction (MI)**: Chew 2 to 4 tablets upon presentation or within 48 hours of stroke. Not recommended for patients less than 18 years of age who are recovering from chickenpox or flu-like symptoms.
Tablet 325 mg (not enteric coated)	Chew ½ or 1 tablet upon presentation or within 48 hours of stroke	Chew ½ or 1 tablet upon presentation or within 48 hours of stroke. Not recommended for patients less than 18 years of age who are recovering from chickenpox or flu-like symptoms.
Diphenhydramine HCL Injection, USP (50 mg/ml)**	10 mg to 50 mg IV/IM (not to exceed 400 mg/day) If IV route, IV push at a rate of ≤25 mg/min	**Children:** 1 to 2 mg/kg/dose IV/IM (not to exceed 50 mg/dose). If IV route, IV push at a rate of ≤25 mg/min. **Infants:** 1 to 2 mg/kg/dose IV/IM (not to exceed 50 mg/dose). **Neonates (≤ 4 weeks)/premature infants:** NOT RECOMMENDED
Liquid (12.5 mg/5 ml)	25 to 50 mg every 4 to 6 hours; max 300 mg/day	**Children:** weight in pounds **lbs** / **ml**: 20 to 24 lbs – 4 ml; 25 to 37 lbs – 5 ml; 38 to 49 lbs – 7.5 ml; 50 to 99 lbs – 10 ml DO NOT GIVE MORE THAN 4 DOSES IN 24 HOURS. Do not use with any other medicine with diphenhydramine in it. **Under 2 years old:** NOT RECOMMENDED

Reviewed and approved by:_____ Date:_____

Print name and Title:_____

Rx name	Adults	Pediatrics
Diphenhydramine HCL (continued) Chewable Tablets (12.5 mg)	2 to 4 chewable tablets every 4 to 6 hours	**Children:** weight in pounds **lbs** | **20 to 24** | **25 to 37** | **38 to 49** | **50 to 99** **tablet** | N/A | 1 | 1 ½ | 2 DO NOT GIVE MORE THAN 4 DOSES IN 24 HOURS. Do not use with any other medicine with diphenhydramine in it. **Under 2 years old:** NOT RECOMMENDED
Tablets (25 mg)	Take 25 to 50 mg by mouth	NOT RECOMMENDED. Refer to parenteral route or oral solution.
Epinephrine Injection, 1:1,000 (1 mg/ml)****	0.3 to 0.5 mg IM may repeat every 5 to 10 minutes	0.01 mg/kg IM (up to maximum of 0.3 mg). May repeat every 5 to 10 minutes as needed.
Injection, 1:10,000 (0.1 mg/ml)	0.1 to 0.25 mg IV (1 to 2.5 ml of 1:10,000 solution) injected slowly once.	**Infants:** 0.05 mg IV slowly once, may repeat at 20 to 30 minute intervals as needed. **Neonates (≤ 4 weeks):** 0.01 mg/kg of body weight IV slowly once.
Auto-injector: **Epipen** (Epinephrine 0.3 mg) **Epipen Jr** (Epinephrine 0.15 mg)	**> 66 lbs**: 0.3 mg/dose IM or subcutaneous into the anterolateral aspect of the thigh.	**33 to 66 lbs**: 0.15 mg/dose IM or subcutaneous into the anterolateral aspect of the thigh. **< 33 lbs:** NOT RECOMMENDED
Auvi Q (Epinephrine 0.1 mg, 0.15 mg, 0.3 mg)	**> 66 lbs**: 0.3mg IM or subcutaneous into anterolateral aspect of the thigh, through clothing if necessary.	**33 to 66 lbs**: 0.15mg IM or subcutaneous into anterolateral aspect of the thigh, through clothing if necessary. **16.5 - 33 lbs**: 0.1mg IM or subcutaneous into anterolateral aspect of the thigh, through clothing if necessary.
Glucagon/Glucose Injection**** (emergency medication for low blood sugar) 1 mg (1 unit)	**< 20 kg**: 0.5 mg or 20 to 30 mcg/kg IM, IV or subcutaneous. **> 20 kg**: 1 mg IM, IV or subcutaneous. If the patient does not respond in 15 minutes, may give 1 to 2 more doses.	**< 20 kg**: 0.5 mg or 20 to 30 mcg/kg IM, IV or subcutaneous **> 20 kg**: 1 mg IM, IV or subcutaneous (If the patient does not respond in 15 minutes, may give 1 to 2 more doses).
Tablet	15 gm (3 to 4 tablets) by mouth, may repeat in 15 minutes if hypoglycemic symptoms do not resolve.	**Children:** 10 to 20 gm (0.3 gm/kg) by mouth, may repeat in 15 minutes if hypoglycemic symptoms do not resolve. **Infants & Neonates (≤ 4 weeks):** NOT RECOMMENDED. Parenteral route recommended (IV dextrose or IM glucagon).
Naloxone* Injection solution injection (0.4 or 1 mg/mL)	0.4 mg to 2 mg IV, IM, or subcutaneous up to a total dose of 10 mg, may repeat every 2 to 3 minutes PRN	0.01 mg/kg IV, IM or subcutaneous, may repeat dose every 2 to 3 minutes as needed
Auto-injector (2 mg in 0.4 ml)	2 mg IM or subcutaneous into the anterolateral aspect of	

Reviewed and approved by:_____ Date:_____

Print Name and Title: _____

Rx name	Adults	Pediatrics
Naloxone* (continued) Nasal spray (4 mg/actuation)	the thigh, may repeat same dose after 2 to 3 minutes. Spray 4 mg into 1 nostril. If desired response is not achieved after 2 to 3 minutes, give a second dose intranasally into alternate nostril.	2 mg IM or subcutaneous into the anterolateral aspect of the thigh, may repeat same dose after 2 to 3 minutes. Spray 4 mg into 1 nostril. If desired response is not achieved after 2 to 3 minutes, give a second dose intranasally into alternate nostril.
Nitroglycerin* SL tablets (0.3 mg or 0.4 mg) Spray (0.4 mg)	0.3 to 0.4 mg sublingually or in buccal pouch at onset, may repeat in 5 minutes; max 3 tabs in 15 minutes. Prophylaxis: 5 to 10 minutes before activity. Spray 0.4 mg (1 spray) sublingually every 5 minutes up to 3 doses.	NOT RECOMMENDED FOR UNDER 18 YEARS OLD NOT RECOMMENDED FOR UNDER 18 YEARS OLD
Oxygen delivery system – tank is at least 3/4 full if only one tank is available	6 to 8 L/minute May consider any oxygen delivery systems if appropriate.	**Children:** 1 to 4 L/minute Nasal prongs or nasal catheters preferred; can consider face mask, head box, or incubator for older children. **Infants & Neonates (≤ 4 weeks):** 1 to 2 L/minute Nasal prongs or nasal catheters preferred.
Optional emergency medications – not required for Medi-Cal Managed Care providers		
Ammonia inhalants	Crack open one (1) capsule	Same as adult
Other:		
Other:		

* Only one emergency medication strength or route is required.

** This medication strength and route treats the widest age range of the population and meets the state requirement for this medication category. All medication strengths and routes must be considered to provide emergency treatment for the population served, as applicable.

Emergency Kit Must Include:

- Appropriate Sizes ESIP needles/syringes
- Alcohol Wipes
- Nasal Cannula/ Oxygen Mask (Infant, Child, Adult)
- Ambu Bags (Infant, Child, Adult)
- Bulb Syringe
- Oxygen Tank (at least ¾ full)

References:
https://www.pdr.net/drug-summary/Albuterol-Sulfate-Inhalation-Solution-0-083--albuterol-sulfate-1427
https://www.accessdata.fda.gov/drugsatfda_docs/label/2013/091526lbl.pdf
https://www.benadryl.com/benadryl-dosing-guide
https://www.health.harvard.edu/heart-health/aspirin-for-heart-attack-chew-or-swallow
https://www.pdr.net/drug-summary/Adrenalin-epinephrine-3036
https://www.pdr.net/drug-summary/Glucagon-glucagon--rDNA-origin--290
https://medlineplus.gov/druginfo/meds/a682480.html#:~:text=Glucagon%20is%20used%20along%20with,stored%20sugar%20to%20the%20blood
https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/narcan-naloxone-nasal-spray-approved-reverse-opioid-overdose
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5753997/
https://www.accessdata.fda.gov/drugsatfda_docs/label/2014/021134s007lbl.pdf (Page 8)

Reviewed and approved by:_____ Date:_____

Print Name and Title: _____

SAMPLE

MONTHLY EXPIRATION DATE & VERIFICATION LOG

YEAR: _____

Please initial each category as you check the Medication and Equipment.

Month	**Oxygen Tank at least ¾ Full with cannula or mask**	**Emergency Kit – Medications/ Equipment**	**Sample Medications**	**In-House Medications**	**Vacutainers/ Lab Supplies – Culture Tubes**	Quality Control Solutions	Other:	Other:
January								
February								
March								
April								
May								
June								
July								
August								
September								
October								
November								
December								

Initial	**Signature**

Calibration Certificate

e3 Diagnostics
Your Local Equipment Experts
909 S Tremont Street, Oceanside, CA 92054

Certificate information

Date of calibration: **10/26/2023**
Certificate number: [redacted]

Customer Information

Account Number: [redacted]
[redacted]
United States

Equipment Information

Manufacturer:	**WELCH ALLYN**
Model:	**AM282**
Serial number:	**GS0103741**
Asset tag no:	
Next calibration date:	**10/25/2024**
Firmware:	**1.11**
Equipment type:	**3**

Result of calibration

All of the measurements are within the indicated tolerance with a coverage probability of 95%.

Calibration status

Adjustment has been made
No repair has been made

Ambient conditions

Temperature:	**21.0 ± 3 °C**
Humidity:	**49 ±50 %rh**
Air pressure:	**97.9 ±5 kPa**

Equipment Calibration Summary

		Pure Tone	Distortion test	Linearity test	Pulse test	Cross Talk test
Transducer:	**AUD - DD45 (R)**	●	●	●	●	●
Serial number:	**GW0103741B**					
Transducer:	**AUD - DD45 (L)**	●	●	●	●	●
Serial number:	**GW0103741A**					

Calibrated by

[redacted]
Sales / Service Technician
[redacted]

Calibration Certificate

Certificate number: 858X-QJW3-275

Calibration equipment

Equipment type	Manufacturer	Model	Serial number	Next calibration date	Equipment id
Coupler	Larson Davis	AEC100	SDG-MR101	N/A	DA3B7A59-57C6-46D5-8AE9-C228281920E0
Microphone	Larson Davis	2575	2617	9/7/2024	D5F3E904-2FB2-49AD-8ACE-965FB2B1B6B1
Preamp	GRAS	26AK	482927	9/7/2024	3FF68C3E-D3F1-45F2-A138-5D171DD6DAF2
Sound level meter	DGS	Calluna	26942923	9/7/2024	EDB88600-405E-44A2-9F07-D526DAED90D3

Uncertainty of measurement:

For each measurement parameter the total estimated uncertainty is tabulated in the "U95" column. The reported expanded uncertainty is based on a standard uncertainty multiplied by a coverage factor k =2, providing a coverage probability of approximately 95%. The uncertainties quoted relate only to the measured values obtained at the time of test and carry no implication regarding the long term stability of the instrument under test.

Transducer: Model AUD - DD45 (R), Serial number GW0103741B

Pure Tone

Status	Signal type	Target Freq	Measured Freq	Tolerance Freq	Deviation Freq	Uncertainty Freq(U95%)	Target level	Target level	Measured	Tolerance	Deviation	Adjustment	Uncertainty (U95 %)
Pass / Fail		Hz	Hz	Hz	Hz	±%	HL dB	SPL dB	SPL dB	±dB	SPL dB	Post - Pre	±dB
Passed	Pure Tone	125	125.0	2.5	0.0	0.1	60	107.5	107.7	+3 / -3	0.2		0.7
Passed	Pure Tone	250	250.0	5.0	0.0	0.1	70	97	97.0	+3 / -3	0.0		0.7
Passed	Pure Tone	500	500.0	10.0	0.0	0.1	70	83	83.4	+3 / -3	0.4		0.7
Passed	Pure Tone	750	750.0	15.0	0.0	0.1	70	76.5	76.9	+3 / -3	0.4		0.7
Passed	Pure Tone	1,000	1,000.0	20.0	0.0	0.1	70	76	75.5	+3 / -3	-0.5		0.7
Passed	Pure Tone	1,500	1,500.0	30.0	0.0	0.1	70	78	78.0	+3 / -3	0.0		0.7
Passed	Pure Tone	2,000	2,000.0	40.0	0.0	0.1	70	78	78.5	+3 / -3	0.5		0.7
Passed	Pure Tone	3,000	3,000.0	60.0	0.0	0.1	70	78	78.2	+3 / -3	0.2		0.7
Passed	Pure Tone	4,000	4,000.0	80.0	0.0	0.1	70	79	78.9	+3 / -3	-0.1		0.7
Passed	Pure Tone	6,000	6,000.0	120.0	0.0	0.1	70	90.5	90.0	+5 / -5	-0.5		0.7
Passed	Pure Tone	8,000	8,000.0	160.0	0.0	0.1	70	82	81.4	+5 / -5	-0.6		0.7

Reference Standard ANSI S3.6:2018
Tolerance Standard ANSI S3.6:2018
Ear Simulator Standard IEC 60318-3:1998

Distortion test

Status	Target Frequency	HL Target level	Tolerance 2nd	2nd Harmonic	Tolerance 3nd	3nd Harmonic	Tolerance 4nd	4nd Harmonic	Tolerance Total	Total Distortion	Uncertainty (U95 %)
Pass / Fail	Hz	HL dB	%	%	%	%	%	%	%	%	±dB
Passed	250	80	2.0	0.1	2.0	0.0	0.3	0.0	2.5	0.1	0.3
Passed	500	100	2.0	0.1	2.0	0.0	0.3	0.0	2.5	0.1	0.3
Passed	1,000	100	2.0	0.0	2.0	0.0	0.3	0.0	2.5	0.0	0.3
Passed	2,000	100	2.0	0.1	2.0	0.0	0.3	0.0	2.5	0.1	0.3
Passed	4,000	100	2.0	0.1	2.0	0.0	0.3	0.0	2.5	0.1	0.3

Reference Standard ANSI S3.6:2018
Tolerance Standard ANSI S3.6:2018
Ear Simulator Standard IEC 60318-3:1998

Calibration Certificate

Certificate number: 858X-QJW3-275

Linearity test

Status	Test Frequency	HL Test level	Target SPL	Measured SPL	Tolerance SPL	Deviation SPL	Uncertainty (U95 %)
Pass / Fail	Hz	HL dB	SPL dB	SPL dB	SPL dB	SPL dB	±dB
Passed	4,000	0	9	7.6	--	0.13	0.4
Passed	4,000	5	14	12.4	--	0.13	0.4
Passed	4,000	10	19	17.4	--	0.02	0.4
Passed	4,000	15	24	22.5	--	0.08	0.4
Passed	4,000	20	29	27.4	--	0.08	0.4
Passed	4,000	25	34	32.4	--	0.07	0.4
Passed	4,000	30	39	37.3	--	0.07	0.4
Passed	4,000	35	44	42.4	--	0.10	0.4
Passed	4,000	40	49	47.3	--	0.10	0.2
Passed	4,000	45	54	52.3	--	0.03	0.2
Passed	4,000	50	59	57.3	--	0.10	0.2
Passed	4,000	55	64	62.2	--	0.10	0.2
Passed	4,000	60	69	67.3	--	0.10	0.2
Passed	4,000	65	74	72.2	--	0.10	0.2
Passed	4,000	70	79	77.2	--	0.08	0.2
Passed	4,000	75	84	82.1	--	0.08	0.2
Passed	4,000	80	89	87.2	--	0.04	0.2
Passed	4,000	85	94	92.2	--	0.11	0.2
Passed	4,000	90	99	97.1	--	0.11	0.2
Passed	4,000	95	104	102.1	--	0.11	0.2
Passed	4,000	100	109	107.0	--	0.11	0.2

Reference Standard ANSI S3.6:2018
Tolerance Standard ANSI S3.6:2018
Ear Simulator Standard IEC 60318-3:1998

Pulse test

Status	Target Frequency	Measured Frequency	HL	Rise time	Tolerance Rise	Fall time	Tolerance Fall	Over shoot	Tolerance Overshoot	Pulse width	Off level	Tolerance Offlevel
Pass / Fail	Hz	Hz	HL dB	ms	ms	ms	ms	dB	dB	ms	dB	dB
Passed	4,000	4,000.0	90	32.9	+ 50 - 20	33.1	+ 50 - 20	0.0	< 1	60.5	-83.6	< 70

Tolerance Standard ANSI S3.6:2018
Ear Simulator Standard IEC 60318-3:1998

Cross Talk test

Status	Target Frequency	Measured Frequency	HL	Cross talk	Tolerance Level	Deviation Level	Deviation Level
Pass / Fail	Hz	Hz	HL dB	dB	dB	dB	±dB
Passed	4,000	4,000.0	90	16.6	< 70	81.7	0.7

Reference Standard ANSI S3.6:2018
Tolerance Standard ANSI S3.6:2018
Ear Simulator Standard IEC 60318-3:1998

Calibration Certificate

Certificate number: 858X-QJW3-275

Transducer: Model AUD - DD45 (L), Serial number GW0103741A

Pure Tone

Status	Signal type	Target Freq	Measured Freq	Tolerance Freq	Deviation Freq	Uncertainty Freq(U95%)	Target level	Target level	Measured	Tolerance	Deviation	Adjustment	Uncertainty (U95 %)
Pass / Fail		Hz	Hz	Hz	Hz	±%	HL dB	SPL dB	SPL dB	±dB	SPL dB	Post - Pre	±dB
Passed	Pure Tone	125	125.0	2.5	0.0	0.1	60	107.5	108.1	+3 / -3	0.6		0.7
Passed	Pure Tone	250	250.0	5.0	0.0	0.1	70	97	97.3	+3 / -3	0.3		0.7
Passed	Pure Tone	500	500.0	10.0	0.0	0.1	70	83	83.3	+3 / -3	0.3		0.7
Passed	Pure Tone	750	749.9	15.0	0.1	0.1	70	76.5	76.8	+3 / -3	0.3		0.7
Passed	Pure Tone	1,000	1,000.0	20.0	0.0	0.1	70	76	76.2	+3 / -3	0.2		0.7
Passed	Pure Tone	1,500	1,500.0	30.0	0.0	0.1	70	78	78.0	+3 / -3	0.0		0.7
Passed	Pure Tone	2,000	2,000.0	40.0	0.0	0.1	70	78	78.1	+3 / -3	0.1		0.7
Passed	Pure Tone	3,000	3,000.0	60.0	0.0	0.1	70	78	78.1	+3 / -3	0.1		0.7
Passed	Pure Tone	4,000	4,000.0	80.0	0.0	0.1	70	79	78.9	+3 / -3	-0.1		0.7
Passed	Pure Tone	6,000	6,000.0	120.0	0.0	0.1	70	90.5	90.9	+5 / -5	0.4		0.7
Passed	Pure Tone	8,000	8,000.0	160.0	0.0	0.1	70	82	81.9	+5 / -5	-0.1		0.7

Reference Standard ANSI S3.6:2018
Tolerance Standard ANSI S3.6:2018
Ear Simulator Standard IEC 60318-3:1998

Distortion test

Status	Target Frequency	HL Target level	Tolerance 2nd	2nd Harmonic	Tolerance 3nd	3nd Harmonic	Tolerance 4nd	4nd Harmonic	Tolerance Total	Total Distortion	Uncertainty (U95 %)
Pass / Fail	Hz	HL dB	%	%	%	%	%	%	%	%	±dB
Passed	250	80	2.0	0.1	2.0	0.0	0.3	0.0	2.5	0.1	0.3
Passed	500	100	2.0	0.0	2.0	0.0	0.3	0.0	2.5	0.0	0.3
Passed	1,000	100	2.0	0.0	2.0	0.0	0.3	0.0	2.5	0.0	0.3
Passed	2,000	100	2.0	0.1	2.0	0.0	0.3	0.0	2.5	0.1	0.3
Passed	4,000	100	2.0	0.1	2.0	0.0	0.3	0.0	2.5	0.1	0.3

Reference Standard ANSI S3.6:2018
Tolerance Standard ANSI S3.6:2018
Ear Simulator Standard IEC 60318-3:1998

Linearity test

Status	Test Frequency	HL Test level	Target SPL	Measured SPL	Tolerance SPL	Deviation SPL	Uncertainty (U95 %)
Pass / Fail	Hz	HL dB	SPL dB	SPL dB	SPL dB	SPL dB	±dB
Passed	4,000	0	9	7.6	--	0.19	0.4
Passed	4,000	5	14	12.5	--	0.19	0.4
Passed	4,000	10	19	17.4	--	0.07	0.4
Passed	4,000	15	24	22.4	--	0.02	0.4
Passed	4,000	20	29	27.4	--	0.01	0.4
Passed	4,000	25	34	32.4	--	0.06	0.4
Passed	4,000	30	39	37.3	--	0.06	0.4
Passed	4,000	35	44	42.3	--	0.11	0.4
Passed	4,000	40	49	47.2	--	0.11	0.2
Passed	4,000	45	54	52.3	--	0.04	0.2
Passed	4,000	50	59	57.3	--	0.11	0.2
Passed	4,000	55	64	62.2	--	0.11	0.2
Passed	4,000	60	69	67.2	--	0.11	0.2
Passed	4,000	65	74	72.1	--	0.11	0.2
Passed	4,000	70	79	77.1	--	0.10	0.2
Passed	4,000	75	84	82.0	--	0.10	0.2
Passed	4,000	80	89	87.0	--	0.03	0.2
Passed	4,000	85	94	92.1	--	0.12	0.2
Passed	4,000	90	99	97.0	--	0.12	0.2
Passed	4,000	95	104	102.0	--	0.12	0.2
Passed	4,000	100	109	106.9	--	0.12	0.2

Reference Standard ANSI S3.6:2018
Tolerance Standard ANSI S3.6:2018
Ear Simulator Standard IEC 60318-3:1998

Calibration Certificate

Certificate number: 858X-QJW3-275

Pulse test

Status	Target Frequency	Measured Frequency	HL	Rise time	Tolerance Rise	Fall time	Tolerance Fall	Over shoot	Tolerance Overshoot	Pulse width	Off level	Tolerance Offlevel
Pass / Fail	Hz	Hz	HL dB	ms	ms	ms	ms	dB	dB	ms	dB	dB
Passed	**4,000**	**4,000.0**	**90**	**32.9**	**+ 50 - 20**	**33.1**	**+ 50 - 20**	**0.0**	**< 1**	**60.5**	**-82.2**	**< 70**

Tolerance Standard **ANSI S3.6:2018**
Ear Simulator Standard **IEC 60318-3:1998**

Cross Talk test

Status	Target Frequency	Measured Frequency	HL	Cross talk	Tolerance Level	Deviation Level	Deviation Level
Pass / Fail	Hz	Hz	HL dB	dB	dB	dB	±dB
Passed	**4,000**	**4,000.0**	**90**	**1.3**	**< 70**	**97.1**	**0.7**

Reference Standard **ANSI S3.6:2018**
Tolerance Standard **ANSI S3.6:2018**
Ear Simulator Standard **IEC 60318-3:1998**

Pass/Fail test

Question	Answer
Other unwanted sounds	**Pass**
Mechanical Integrity	**Pass**
Subject Response	**Pass**
Overall Condition	**Good**
Overall Device	**Pass**

Notes

No faults found. Return to service.

NOTICE TO PATIENTS

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

To check up on a license or to file a complaint go to

www.mbc.ca.gov,

email: licensecheck@mbc.ca.gov,

or call (800) 633-2322.

AVISO A LOS PACIENTES

Los médicos están autorizados y regulados por la Junta Médica de California.

Para comprobar la validez de una licencia o presentar una queja, ingrese a

www.mbc.ca.gov,

envíe un correo electrónico a licensecheck@mbc.ca.gov,

o llame al (800) 633-2322.

NOTIFICATION TO CONSUMERS

Physician Assistants are licensed and regulated by the

Physician Assistant Committee
(916) 561-8780
www.pac.ca.gov

AVISO A LOS CONSUMIDORES

Los Asistentes Médicos están autorizados y reglamentados por Physician Assistant Committee

(916) 561- 8780

www.pac.ca.gov

NOTICE TO CONSUMERS

Osteopathic physicians and surgeons (D.O.) are licensed and regulated by the Osteopathic Medical Board of California.

(916) 928-8390 www.ombc.ca.gov

To check the status of your physician and surgeon D.O. license online, go to https://search.dca.ca.gov

To file a complaint against the physician and surgeon D.O., complete the online complaint form on the Osteopathic Medical Board of California website or email: osteopathic@dca.ca.gov

NOTICE TO CONSUMERS

Nurse practitioners are licensed and regulated by the

Board of Registered Nursing

(916) 322-3350

www.rn.ca.gov

Medical Assistant Letter of Competency

To Whom It May Concern:

This is to certify that _____ has demonstrated and completed on the job training as "Medical Assistant" here at _____ under the auspices of the undersigned as follows and in compliance with Business and Professions Code § 2069 and 2070 and California Code of Regulations Title 16, § 1366. 1366.1. 1366.1, 1366.3 and 1366.4.

Check all the boxes that apply:

- ☐ A. Ten clock hours of training in venipuncture and skin puncture for the purpose of drawing blood.
- ☐ B. Ten clock hours of training in administering injections and performing skin tests.
- ☐ C. Satisfactory performance by the trainee of at least ten of each of the following procedures: intramuscular injections, subcutaneous injections, skin tests, venipunctures and other skin punctures performed in the office.
- ☐ D. Training A through C above, shall include knowledge of the following:
    - ☐ 1. Pertinent anatomy and physiology appropriate to the procedure
    - ☐ 2. Demonstrates knowledge and correct use of all medical equipment they are expected to operate within their scope of work.
    - ☐ 3. Proper technique including sterile technique
    - ☐ 4. Hazards and complications
    - ☐ 5. Demonstrates the ability to perform all testing operations reliably and to report results accurately.
    - ☐ 6. Patient care following treatments and tests
    - ☐ 7. Emergency Procedures
    - ☐ 8. California law and regulations for Medical Assistants
- ☐ E. Appropriate training and supervisions in all medication administration methods performed within their scope of work.
- ☐ F. Demonstrates competency in performing vital signs (oral/tympanic/rectal temperature, respirations, apical/radial pulse, blood pressure and height/length, weight).
- ☐ G. Demonstrates competency in performing Snellen screening and audiometric screening.
- ☐ H. Demonstrates competency in operating autoclave and/or cold sterilization.
- ☐ I. Demonstrate competency in performing EKGs.

Medical Assistant Letter of Competency

Pediatric preventive care screenings for ages 0 to 20 years guided by the American Academy of Pediatrics requirements. Please refer to training links below.

☐ J. Anthropometric Measurements: Accurately obtaining and documenting patients' anthropometric data, including head circumference, height, weight, BMI, and plotting values on WHO and CDC growth charts.

☐ K. Hearing Screening: Conducting audiometric screenings to directly obtain results without requiring interpretive analysis or results by the medical assistant.

☐ L. Vision Screening: Conducting vision screenings, including visual field and basic ophthalmic tests, to directly obtain results without the need for medical assistant interpretation.

☐ M. Dental Services: Performing oral and fluoride screenings, establish dental home, referral to a dentist at least annually and applying fluoride varnish.

Anthropometric Measurements:

- Measuring Children's Height and Weight | BMI | CDC
- 2017_Anthropometry_Procedures_Manual.pdf (cdc.gov)

Hearing Screening:

- DHCS/CHDP Audiometric Screening Play Audiometry YouTube
- County of Riverside CHDP – Audiometric Materials

Vision Screening:

- Preschool Eye Screening, Made Fast, Easy, and Accurate: Guidelines for Primary Care Providers
- County of Riverside CHDP – Vision Training Materials
- AAP Nevada Chapter - Practical Aspects of Vision Screening for the Pediatrician (YouTube) https://youtu.be/kcIuMd591Xo?si=iz3QLIGg1VXDsqes

Dental Services:

- All Courses | Smiles for Life Oral Health

_____ _____

Physician's Signature Date

SAMPLE

Sample

Mid-level Supervision of Medical Assistant

(Requires approval from Physician)

This is to certify that the NP/PA may supervise the Medical Assistant_____, MA in the absence of the physician in compliance with Business and Professions Code Sections 2069 (a) (2).

Check all boxes that apply:

- ☐ **A.** Venipuncture and skin puncture for the purpose of withdrawing blood.
- ☐ **B**. Administering injections and performing skin tests.
- ☐ **C.** Intramuscular, subcutaneous, intradermal injections, skin test, venipunctures and skin punctures.
- **D.** Medical Assistant may assist the Mid-level with the following:
  - ☐ **1.** Pertinent anatomy and physiology appropriate to the procedure.
  - ☐ **2.** Demonstrates knowledge and correct use of all medical equipment they are expected to operate within their score of work.
  - ☐ **3.** Proper technique including sterile
  - ☐ **4.** Hazards and complications.
  - ☐ **5.** Demonstrates the ability to perform all testing operations reliably and to report results accurately.
  - ☐ **6.** Patient care following treatments and tests.
  - ☐ **7.** Emergency Procedures.
- ☐ **E.** All medication administration methods performed within their scope of work.
- ☐ **F.** Performs vital signs (oral/tympanic/rectal temperature, respirations, apical/radial pulse, blood pressure) and height / length, weight.
- ☐ **G.** Performs Snellen screening and audiometric screening.
- ☐ **H.** Operates autoclave and / or cold sterilization.
- ☐ **I.** Performs EKGs.
- ☐ **J.** Other

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

*Required for offices if MD/DO is not on site during all hours of operation.

*****SAMPLE*****

Protocol for Administering Medication / Vaccines

I. Guidelines
- A. Perform hand hygiene upon entering the patient room
- B. Identify the patient when you walk into the exam room.
  1. Patient Name
  2. Date of birth
- C. Provide a Vaccine Information Sheet (VIS) to the patient prior to drawing up vaccine.
- D. Verify any allergies prior to administration.
- E. Confirm the medication administration.
- F. Perform the **Seven Rights of Medication Administration.**
  1. **Right patient** – Prepare medication one patient at a time
  2. **Right Drug** – Check and/or have verified label of vaccine/medication is the correct vaccine/medication ordered for correct patient
  3. **Right Dose** – Ensure dose to be given is the correct dose that was ordered
  4. **Right Time** – Ensure vaccine/medication administration is given at the correct time
  5. **Right Route** – Ensure drug is given via the route that is ordered
  6. **Right Reason** – Verify correct indication for vaccine/medication use
  7. **Right Documentation** – Ensure timely and complete documentation of vaccine/medication give to include:
     - a) Date of administration
     - b) Vaccine manufacturer
     - c) Vaccine lot number
     - d) Name and title of the person who administered the vaccine
     - e) Vaccine Information Statement (VIS)
       1) Date printed on the VIS
       2) Date the VIS was given to the patient or parent/guardian
     - f) CAIR2 Registry

II. Preparation
- A. Select the site of administration for an intramuscular injection
- B. Select needle and syringe size appropriate to the amount of solution and site of administration.
- C. Perform hand hygiene prior to preparing vaccine or medication.
- D. Prepare the correct dose, expelling any excess air from the syringe
- E. Present medication to MD or Licensed personnel to verify the correct medication and dosage.

III. Administration
- A. Perform hand hygiene when entering room and prior to gloving
- B. Provide explanation to the patient of any side effects.
- C. Put on gloves and position the patient for the injection.
- D. Clean the site with an alcohol swab.
- E. Inject the solution slowly and steadily.
- F. Withdraw the needle quickly (Do Not recap) and place in sharps container.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
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AN EXPLANATION OF STANDARDIZED PROCEDURE REQUIREMENTS FOR NURSE PRACTITIONER PRACTICE

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

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

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

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

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

Scope of Medical Practice

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

Standardized Procedure Guidelines.

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

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

(b) Each standardized procedure shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

SUGGESTED FORMAT FOR STANDARDIZED PROCEDURES

I. POLICY

1. Function(s): (2)*
2. Circumstances under which R.N. may perform function: (2)
   a. Setting (9)
   b. Supervision (7)
   c. Patient Conditions
   d. Other

II. PROTOCOL (3)

1. Definitions
2. Data base
   a. Subjective
   b. Objective
3. Diagnosis
4. Plan
   a. Treatment
   b. Patient conditions requiring consultation (8)
   c. Education - patient/family
   d. Follow up
5. Record keeping (10)

III. REQUIREMENTS FOR REGISTERED NURSE: (4)(5)

1. Nurse practitioner education program, specialty
2. Advance level training
3. Experience as a nurse practitioner
4. National Certification in a specialty
5. Method of initial and continuing evaluation of competence

IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

1. Method: (Title 16, CCR Section 1474(a))
2. Review schedule (11)
3. Signatures of authorized personnel approving the standardized procedure, and dates: (1)
   a. Nursing
   b. Medicine
   c. Administration

V. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES (6)

1.
2.

*** Numbers in parentheses correspond to Board of Registered Nursing guideline numbers in Title 16, CCR Section 1474.**

EXAMPLE A (Process Protocol)

The Board of Registered Nursing does not recommend or endorse the medical management of this sample standardized procedure. It is intended as a guide for format purposes only.

Standardized Procedures

General Policy Component

I. Development and Review

A. All standardized procedures are developed collaboratively and approved by the Interdisciplinary Practice Committee (IDPC) whose membership consists of nurse practitioners, nurses, physicians, and administrators and must conform to all 11 steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

B. All standardized procedures are to be kept in a manual which includes dated, signed approval sheets of the persons covered by the standardized procedures.

C. All standardized procedures are to be reviewed every three years and as practice changes by the IDPC.

D. All changes or additions to the standardized procedures are to be approved by the IDPC accompanied by a dated and signed approval sheet.

II. Scope and Setting of Practice

A. Nurses may perform the following functions within their training specialty area and consistent with their experience and credentialing: assessment, management, and treatment of episodic illnesses, chronic illness, contraception, and the common nursing functions of health promotion, and general evaluation of health status (including but not limited to ordering laboratory procedures, x-rays, and physical therapies, recommending diets, and referring to Specialty Clinics when indicated).

B. Standardized procedure functions, such as managing medication regimens, are to be performed in (list area, i.e., short appointment clinic). Consulting physicians are available to the nurses in person or by telephone.

C. Physician consultation is to be obtained as specified in the individual protocols and under the following circumstances:

1. Emergent conditions requiring prompt medical intervention after initial stabilizing care has been started.

2. Acute decompensation of patient situation.

3. Problem which is not resolving as anticipated.

4. History, physical, or lab findings inconsistent with the clinical picture.

5. Upon request of patient, nurse, or supervising physician.

III. Qualifications and Evaluations

A. Each nurse performing standardized procedure functions must have a current California registered nursing license, be a graduate of an approved Nurse Practitioner Program, and be certified as a Nurse Practitioner by the California Board of Registered Nursing.

B. Evaluation of nurses' competence in performance of standardized procedure functions will be done in the following manner:

1. **Initial:** at 3 months, 6 months and 12 months by the nurse manager through feedback from colleagues, physicians, and chart review during performance period being evaluated.

2. **Routine:** annually after the first year by the nurse manager through feedback from colleagues, physicians, and chart review.

3. **Follow-up:** areas requiring increased proficiency as determined by the initial or routine evaluation will be re-evaluated by the nurse manager at appropriate intervals until acceptable skill level is achieved, e.g. direct supervision.

IV. Authorized Nurse Practitioners

List each

V. Protocols

The standardized procedure protocols developed for use by the nurses are designed to describe the steps of medical care for given patient situations. They are to be used in the following circumstances: management of acute/episodic conditions, trauma, chronic conditions, infectious disease contacts, routine gynecological problems, contraception, health promotion exams, and ordering of medications.

STANDARDIZED PROCEDURES FOR NURSE PRACTITIONERS

Revised Spring

Interdisciplinary Practice Committee

(signature) _____		(signature) _____	
full name & title	date	full name & title	date
(signature) _____		(signature) _____	
full name & title	date	full name & title	date
(signature) _____		(signature) _____	
full name & title	date	full name & title	date
(signature) _____		(signature) _____	
full name & title	date	full name & title	date

STANDARDIZED PROCEDURES

Management of Common Primary Care Conditions

I. Policy

A. As described in the General Policy Component.

B. Covers only those registered nurses as identified in General Policy Component.

II. Protocol

A. **Definition:** This protocol covers the management of common primary care conditions seen in the outpatient setting, such as eczema, headaches, acne, fatigue syndromes, allergic rhinitis, and low pain.

B. **Database** - Nursing Practice
(Perform usual total nursing assessment to establish data base).

C. **Treatment Plan** - Medical Regimen

1. **Diagnosis**
   a. Most consistent with subjective and objective findings expected by patient. If diagnosis is not clear, assessment to level of surety plus differential diagnosis.
   b. Assessment of status of disease process when appropriate.

2. **Treatment** - (Common nursing functions)
   a. Further lab or other studies as appropriate.
   b. Physical therapy if appropriate.
   c. Diet and exercise prescription as indicated by disease process and patient condition.
   d. Patient education and counseling appropriate to the disease process.
   e. Follow-up appointments for further evaluation and treatment if indicated.
   f. Consultation and referral as appropriate.

3. **Physician Consultation:** As described in the General Policy Component.

4. **Referral to Physician or Specialty Clinic:** Conditions for which the diagnosis and/or treatment are beyond the scope of the nurse's knowledge and/or skills, or for those conditions that require consultation.

5. **Furnishing Medications** - (Medical Regimen)
Follow furnishing protocol, utilizing formulary.

PROTOCOL: DRUGS AND DEVICES

Definition: This protocol covers the management of drugs and devices for women of all ages presenting to _____ clinic. The nurse practitioner may initiate, alter, discontinue, and renew medication included on, but not limited to the attached formulary. All Schedule I and Schedule II drugs are excluded.

Subjective Data: Subjective information will include but is not limited to:

1. Relevant health history to warrant the use of the drug or device.
2. No allergic history specific to the drug or device.
3. No personal and/or family history which is an absolute contraindication to use the drug or device.

Objective Data: Objective information will include but is not limited to:

1. Physical examination appropriate to warrant the use of the drug or device.
2. Laboratory tests or procedures to indicate/contraindicate use of drug or device if necessary.

Assessment: Subjective and objective information consistent for the use of the drug or device. No absolute contraindications of the use of the drug or device.

Plan: Plan of care to monitor effectiveness of any medication or device.

Patient Education: Provide the client with information and counseling in regard to the drug or device. Caution client on pertinent side effects or complications with chosen drug or device.

Consultation and/or Referral: Non-responsiveness to appropriate therapy and/or unusual or unexpected side effects and as indicated in general policy statement.

REFERENCES: PDR '94 50th Edition (list page)
Primary Care Medicine, 3rd Edition, Chapter (list), pp. (list)
Handbook of Gynecology and Obstetrics, 3rd Edition, Chapter (list), pp. (list)

FORMULARY

To include but not limited to those medications listed below:

Antibiotic: Ampicillin, Penicillin, Amoxicillin, Dicloxacillin, Augmentin, Keflex, Tetracycline, Noroxin, Minocin, Vibramycin, Benemid, Macrodantin, Erythromycin, Rocephin, Gantrisin, Trimethoprim/sulfamethoxazole, Nitrofurantoin, Nalidixic acid.

Antidiarrheal: Imodium, Donnagel

Antiemetic: Trans-derm V, Compazine, Phenergan, Tigan

Antifungal: Mycostatin oral suspension/tablets, Nizoral, Monistat, Femstat, Terazol, Gyne-Lotrimin

Antiviral: Zovirax ointment/capsules, Podophyllin 25-75%, Trichloroacetic acid

Antiparasite: Flagyl/Protostat, Kwell lotion/shampoo, RID lotion, Eurax cream

Biologic: RhoGAM, HypRho-D

Chemotherapeutic: 5FU for vaginal or vulvar use

Devices: Diaphragm, cervical cap, IUD, pessary, Norplant

Diuretic: Spironolactone, Dyazide

Hormone: All oral contraceptives, progesterone preparations, Estrogen (Premarin, Estinyl, Delestrogen, Estrovis, Estrace), Estraderm, Protestins (Aygestin, Provera, Micronor, Nor QD, Ovrette), Estrogen vaginal creams (Premarin, Estrace)

Local anesthetic: Xylocaine Jel 2%, Xylocaine 1% injection

Nonsteroidal Anti-inflammatory: Anaprox, Anaprox DS, Suprol, Motrin, Ponstel, Naprosyn, Rufen

Over the counter: Spermicidal agents, cold & cough preparations (non-narcotic), laxatives, stool softeners, antacids, antiflatulents, analgesics, prostaglandin inhibitors, topicals, vitamin/mineral, antihistamines, decongestants, hemorrhoidal/antidiarrheal.

Rectal:	Anusol HC, Wyanoids
Thyroid:	Synthroid, Armour thyroid tablets
Urinary analgesic:	Pyridium
Vaginal:	All appropriate antifungals, Aminocervical cream, Acijel, Betadine, Triple Sulfa cream, Estrogen cream.
Vitamin/Mineral:	Prenatal vitamins, iron pill

EXAMPLE B (Disease Specific)

The Board of Registered Nursing does not recommend or endorse the medical management of this sample standardized procedure. It is intended as a guide for format purposes only.

Standardized Procedures

DEPARTMENT:_____ FACILITY:_____

POLICY

I. FUNCTIONS NURSE PRACTITIONERS MAY PERFORM:

Provide care for patients with acute conditions as covered in attached protocol (see sample attached) and furnish non-controlled drugs and devices to essentially healthy patients.

II. CIRCUMSTANCES UNDER WHICH NURSE PRACTITIONERS MAY PERFORM THESE FUNCTIONS:

A. May furnish non-controlled drugs and devices under standardized procedures under the supervision of a designated physician (or designee).

B. Applies to nurse practitioners working in (indicate departments involved).

III. EXPERIENCE, TRAINING AND/OR EDUCATION REQUIRED OF THE NURSE PRACTITIONER:

Maintains a current California license to practice as an RN, is certified by the State of California as a Nurse Practitioner, has met all the requirements for and has a current Furnishing Number issued by the Board of Registered Nursing. Is oriented to the facility.

IV. METHOD OF INITIAL AND CONTINUED EVALUATION OF COMPETENCE:

General competency is initially evaluated during the probationary period through a proctoring process by the supervising physician. The registered nurse is assigned to and is supervised by a designated physician who is responsible to annually evaluate appropriateness of practice and clinical decision making. A QA review process is established to assure that compliance to standards relating to important aspects of care are maintained.

V. DOCUMENTATION

Documentation required is outlined in each protocol. Patient specific documentation is entered into the patient's medical record.

DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

I. THIS STANDARDIZED PROCEDURE WAS:

Developed by the supervising physician, or designee, and the Nurse Practitioner. Approved by the department Chief, Director of Nursing Practice, Physician-in-Chief or designees, and Medical Group Administrator.

II. THIS STANDARDIZED PROCEDURE WILL BE REVIEWED AT LEAST ANNUALLY.

REVISION DATED _____ REVIEWED DATED _____
_____ _____
_____ _____

III. THE STANDARDIZED PROCEDURE WAS APPROVED BY:

MEDICINE _____ DATE_____
(Chief of Department)

MEDICINE _____ DATE_____
(PIC/Designee)

NURSING _____ DATE_____
(Director of Nursing Practice)

ADMINISTRATION _____ DATE_____
(Medical Group Administrator)

IV. PRACTITIONERS FUNCTION UNDER THIS STANDARDIZED PROCEDURE:

Current list of authorized personnel are on file in the office of the Medical Group Administrator and department manager.

PROTOCOLS (List those applicable)

I.E., Urinary Tract Infection (see attached).
Respiratory tract infection
Otitis Media
Vaginitis

References: List

URINARY TRACT INFECTION PROTOCOL: INITIAL VISIT

I. RATIONALE

This protocol will assist in the differentiation between pyelonephritis and urinary tract symptoms sufficiently to eradicate the symptoms per se rather than attempt to eradicate any bacteriuria that may or may not be present. The design of the protocol for UTI encompasses these principles.

II. SYMPTOMS

A. CYSTITIS

1. FEMALE PATIENTS

Order a STAT CVMS UA for female patients with any of the following symptoms;

a. Dysuria
b. Frequency
c. Urgency
d. Inability to empty bladder completely

2. Male patients

Male patients with any of the above symptoms should be seen by an M.D., not by a NP, unless they have a urethral discharge (possible VD - follow VD protocol).

B. PYELONEPHRITIS

1. In addition to the above symptoms, patients with pyelonephritis may have:
   a. Fever greater than 100.0 F. or
   b. Flank pains, or
   c. Chills, or
   d. Nausea, vomiting or abdominal pain.
2. Continue with protocol through the physical exam with these patients, but then consult supervising physician before deciding on treatment.

III. HISTORY

A. Consult supervising physician if patient has:
   1. A history of kidney problems, or
   2. Is currently pregnant. To ascertain this, always ask for LMP date and record for all female patients.
   3. Diabetes or insulin.
   4. Three or more UTIs in past 12 months

B. Continue with UTI protocol, but also refer patient to GYN if history of:
   1. Vaginal discharge, or
   2. Perineal inflammation.

IV. PHYSICAL EXAM

A. Perform the following examinations:
   1. Abdominal
   2. CVA
   3. Temperature

B. Consult supervising physician if findings of:
   1. Fever greater than 100.0 F. or
   2. CVA tenderness.

V. LAB TESTS

INITIAL URINALYSIS

A. Consult supervising physician if:
   1. Casts
   2. RBCs or protein are positive (without associated WBC abnormality).

B. If UA shows 10 or more WBCs/hpf and patient is symptomatic, give patient antibiotic prescription as described in the treatment section.

C. If UA revealed 0-10 WBCs, review symptoms. If the symptoms are definite and very severe, treat with antibiotics; if symptoms are vague and poorly defined, then give patient symptomatic treatment as described in the treatment section and consider referral to GYN for pelvic.

D. Should the initial UA be "positive": (defined in guidelines below), then give patient a repeat UA slip for the abnormality found with instructions to have that UA one week following completion of treatment.

Positive UA findings are defined as:

Casts: any except occasional hyaline or rare granular
RBCs > 3 (if not menstruating) and WBC < 5
Protein > trace and WBC < 5

VI. TREATMENT

ANTIBACTERIAL TREATMENT

To be given if initial UA reveals 10 or more WBC/hpf, or in any case where symptoms are severe, even if UA revealed, WBC/hpf.

A. Prescribe appropriate antibiotic drug (see p.6)

B. Instruct patient to call in if symptoms do not subside within 72 hours. If patient does call back, information for treatment failure instructions.

SYMPTOMATIC TREATMENT

To be given only if initial UA reveals, 10WBC/Hpf, and patient has minimal or uncertain symptoms. Consider GYN referral for pelvic.

A. Prescribe either Propantheline 15 mg #20 sig: 1-2 QID prn or Belladonna with Pb tabs #15, sig: 1 tab QID prn.
B. Instruct patient to call in if symptoms persist beyond 72 hours or if symptoms worsen at any time.

VII. REPEAT URINALYSIS (CVMS)

A. Consult supervising physician if UA shows casts.
B. If repeat UA confirms abnormality (protein and/or RBC as listed below) refer to Proteinuria and/or Hematuria protocols.

Positive UA findings are defined as:
Casts: any, except occasional hyaline or rare granular
RBCs >3 (if not menstruating) and WBC <5
Protein > trace and WBC <5

UTC PROTOCOL: ANTIBIOTIC TREATMENT

A. If organism found in patient's urine is not listed in the table below, consult supervising physician for treatment.

B. If this is the first antibiotic course (initial visit), assume E coli and use the first listed drug to which patient is not allergic, as listed for E coli in the drug table below.

C. If this is a second antibiotic course (treatment failure), go to the first drug for the organism listed that is not the same as that previously used and to which the patient is not allergic. If the patient is allergic to all drugs listed, consult supervising physician for treatment.

D. Prescribe according to the prescription table which follows:

1. If symptoms have been present within the past 48 hours, use 1 dose treatment.
2. If symptoms have been present longer than 48 hours, use 5-day treatment.
3. If symptoms persists after treatment with first drug, repeat UA and culture and consult supervising physician.

UTI PROTOCOL: TREATMENT FAILURE

If the patient calls in with persisted or recurrent symptoms after the first course of antibiotic treatment, obtain a CVMS urine specimen for UA and culture and sensitivity.

If the UA is negative, wait for the culture results before treating. If the UA is positive, treat with the next drug listed on the Antibiotic Prescription Table and review treatment choice when the culture and sensitivity results are available.

If culture is positive and patients symptoms are improving, stay with the same antibiotic. If not responding after 3 days, switch to a new antibiotic based on culture sensitivity.

Adapted from protocol developed by: _____, NP

_____, MD

(List names of nurse practitioners and physicians who developed the standardized procedure, including the protocol section).

ANTIBIOTIC PRESCRIPTION TABLE

ORGANISM	DRUG
E. Coli Proteus mirabilis	Septra DS, Amoxicillin Macrodantin, Keflex
Aerobacter Klebsiella	Septra DS, Macrodantin Keflex, Ciprofloxacin
Enterococcus	Ampicillin *Consult MD if allergic
Pseudomonas	Ciprofloxacin (Usually not seen in out-patient setting)

DOSAGES

SEPTRA DS	#3 PO at once or 1 bid x 5 days
AMOXICILLIN	500mg 3gms PO at once or 250mg 1 tid x 5 days
MACRODANTIN	100mg qid x 5 days
KEFLEX	250mg qid x 5 days
CIPROFLOXACIN	250mg qid x 5 days

EXAMPLE C (Procedure Specific)

The Board of Registered Nursing does not recommend or endorse the medical management of this sample standardized procedure. It is intended as a guide for format purposes only.

Standardized Procedure for Dispensing by Registered Nurse

I. Policy

A. Drugs and devices listed in the agency formulary and prescribed by a lawfully authorized prescriber may be dispensed.
B. Setting - Adult Clinic.
C. Supervision - None required at the time of dispensing.

II. Protocol

A. Data Base
1. No patient or family history contraindications.
2. Agency required tests and procedures relative to the drug or device being dispensed demonstrate no contraindications.

B. Action
1. Affix label which contains information that follows.
a. Agency name, address and telephone number.
b. Patient's name.
c. Name of the prescriber and initials of the dispenser.
d. Date dispensed.
e. Trade or generic name of dispensed drug.
f. Quantity and strength of dispensed drug.
g. Directions for use of dispensed drug.
h. Expiration date of the drug's effectiveness.
2. Affix any appropriate auxiliary labels.
3. Use child proof containers.
4. Provide patient with appropriate information including:
- directions for taking the drug;
- what to do and whom to contact if side effects occur;
- common side effects;
- possible serious or harmful effects of the drug; and
- any manufacturer-prepared information required by the FDA.

C. Record Keeping - Document in the patient record:
1. Name, dosage, route and amount of the drug dispensed.
2. Lot number and manufacturer's name.
3. Other information, including patient instructions given.
4. Complete information in the pharmacy dispensing log.

D. Consultation - Contact the prescriber if the item is not listed in the agency formulary for RN dispensing or regarding contraindications.

III. Requirements for Registered Nurses

A. Education, training and experience: successful completion of the agency's in-service program on dispensing.

B. Initial evaluation: Demonstration of competency in skill performance to the satisfaction of the Pharmacy Director.

C. On-going evaluation - Monthly random record review by the pharmacist and an annual performance appraisal including observation of dispensing.

IV. Development and Approval of the Standardized Procedure

This standardized procedure was approved by the following:

NURSING_____ DATE _____

MEDICINE_____ DATE _____

PHARMACY_____ DATE _____

ADMINISTRATION _____ DATE _____

The standardized procedure will be reviewed annually.

V. RNs authorized to perform the procedure.

1. _____ DATE _____

2._____ DATE _____

(Site Name)

Physician Associate Practice Agreement

(Controlled Substances Education Course and DEA Registration Completed)

Physician Associate (PA) _____ graduated from _____ on _____.

PA was first granted licensure by the Physician Assistant Committee on _____, which expires _____ unless renewed.

This Practice Agreement has been developed through collaboration among physician _____ and physician associate _____ in Site Name, an Organized Health Care System (as defined in Business & Professions Code (BPC) §3501(j) and hereinafter referred to as the "Practice"), for the purpose of defining the medical services which each and every physician associate ("PA") who executes this Practice Agreement is authorized to perform and to meet the statutory requirement set forth in BPC §3502.3.

1. **Medical Services Authorized:** Pursuant to BPC §3502, the PA is authorized to perform those medical services for which the PA has demonstrated competency through education, training, or experience, under physician supervision as provided in Section 3 of this Practice Agreement. See Appendix A. Subject to the foregoing, the PA is further authorized to: (a) perform the medical functions set forth in BPC §3502.3(b); to supervise medical assistants pursuant to BPC §2069; (c) to provide care and sign forms under the workers' compensation program pursuant to Labor Code §3209.10; and (d) any other services or activities authorized under California law.

2. **Ordering and Furnishing of Drugs and Devices:** In compliance with State and Federal prescribing laws, the PA may order and furnish those drugs and devices, including schedule II through V controlled substances, as indicated by the patient's condition, the applicable standard of care, and in accordance with the PA's education, training, experience, and competency, under physician supervision as provided in Section 3 of this Practice

Agreement. The furnishing and ordering of schedule II drugs shall be only for those illnesses, injuries, and/or conditions for which the standard of care indicates the use of such schedule II drugs. The PA may dispense drugs and devices as provided for in BPC §4170 and request, sign, and receive drug samples as provided for in BPC §4061. Prescribing PA DEA #_____.

3. **Physician Supervision:** Any physician and surgeon of the Practice, who meets the definition of a supervising physician in BPC §3501(e), may provide supervision of a PA in the Practice acting under this Practice Agreement. A supervising physician need not be physically present while the PA provides medical services, but be available by telephone or other electronic means at the time the PA is providing medical services in the Practice. Supervision means that a physician and surgeon oversee and accepts responsibility for the activities of the PA. If rendering services in a general acute care hospital as defined in Health and Safety Code §1250, the PA shall identify his or her supervising physician which has privileges to practice in said hospital. Each time the PA provides care for a patient and enters his or her name, signature, initials, or computer code on a patient's record, chart, or written order, _____ is the supervising physician responsible for the patient, unless otherwise specified in the patient's record.

   Practice site: _____

   Record Review: The supervising physician shall review, countersign, and date a minimum of 5% sample (per IEHP policy) of medical records of patients treated by the physician assistant functioning under these protocols within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

4. **Patient Care Policies and Procedure:** PA shall consult with, and/or refer the patient to, a supervising physician or other healthcare professional when providing medical services to a patient which exceeds the PA's competency, education, training, or experience.

5. **PA Competency and Qualification Evaluation:** Through a peer review process based on the standard of care, the Practice shall regularly evaluate the competency of a PA. The Practice may credential and privilege the PA to ensure that the PA has the qualifications, training, and experience, to perform the medical services, procedures, and drug and device ordering and furnishing authorized under this Practice Agreement.

6. **Emergency Transport and Backup:** In a medical emergency, telephone 911 and emergency services will be summoned to transfer patient to __Name of ER__ at __Address of ER__.

7. **Review of Practice Agreement:** This Practice Agreement shall be reviewed on an annual basis and signed. The agreement will be updated by the Practice when warranted by a change in conditions or circumstances.

The physician and PA listed below collaboratively approve this Practice Agreement governing the medical services of PA(s) in the Practice, on behalf of the Practice, and authorize the physicians on the staff of the Practice to supervise the PA(s) named below effective as of the date signed by the PA. Signing this Practice Agreement does mean the named physician below is accepting responsibility for the medical services provided by the PA(s) named below, they are serving as a supervising physician as set forth in Section 3 of this Practice Agreement.

Physician: _____ License #_____

Supervising Physician Signature & Date: _____

PA: _____ License #_____

Supervising PA Signature & Date: _____

Appendix A

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

- Glucose readings
- Hemoglobin levels
- Urinalysis
- Respiratory and sputum cultures
- Genitourinary specimen testing
- Wound cultures
- Electrocardiogram
- Order radiology testing

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

- Glucose readings
- Hemoglobin levels
- Urinalysis
- Respiratory and sputum cultures
- Genitourinary specimen testing
- Wound cultures
- Electrocardiogram
- Order radiology testing

The PA is authorized to *perform* the following therapeutic procedures:

- Wound closures and repairs
- Suture and staple removals
- Incision and drainage of lesions/abscess
- Therapeutic joint and soft tissue injections and aspirations
- Closed reductions of musculoskeletal injuries
- Extremity splinting and immobilizations
- Nail removals and partial excisions
- Excisional biopsies

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

- Wound closures and repairs
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- Incision and drainage of lesions/abscess
- Therapeutic joint and soft tissue injections and aspirations
- Closed reductions of musculoskeletal injuries
- Extremity splinting and immobilizations
- Nail removals and partial excisions
- Excisional biopsies

INLAND EMPIRE HEALTH PLAN

*** Sample****

Evidence of Staff Training

Employee's Name:		**Employee Signature:**	
Employee's Position:		**Date of Hire:**	

The Following Topics Must Have Training Annually

Topic	Please Check Type of Training Done	Trainer	Annual Training		
			Staff Initials/ Date	Staff Initials/ Date	Staff Initials/ Date
Bloodborne Pathogens Exposure Prevention	☐ Handouts ☐ Video ☐ Lecture ☐ Website ☐ Other				
Infection Control/Universal Precautions	☐ Handouts ☐ Video ☐ Lecture ☐ Website ☐ Other				
Biohazardous Waste Handling	☐ Handouts ☐ Video ☐ Lecture ☐ Website ☐ Other				

The Following Topics Must Have Training At Least Once or As Needed

Topic	Please Check Type of Training Done	Trainer	Staff Initials/ Date
Patient Confidentiality	☐ Handouts ☐ Video ☐ Lecture ☐ Website ☐ Other		
Informed Consent/ Human Sterilization (N/A if no invasive procedures are performed onsite)	☐ Handouts ☐ Video ☐ Lecture ☐ Website ☐ Other		
Prior Authorization Requests	☐ Handouts ☐ Video ☐ Lecture ☐ Website ☐ Other		
Grievance/Complaint Procedure	☐ Handouts ☐ Video ☐ Lecture ☐ Website ☐ Other		
Child/Elder/Domestic Violence Abuse reporting	☐ Handouts ☐ Video ☐ Lecture ☐ Website ☐ Other		
Sensitive Services/Minors' Rights	☐ Handouts ☐ Video ☐ Lecture ☐ Website ☐ Other		
Health Plan Referral Process/procedures/resources	☐ Handouts ☐ Video ☐ Lecture ☐ Website ☐ Other		
Cultural and Linguistics	☐ Handouts ☐ Video ☐ Lecture ☐ Website ☐ Other		
Disability Rights and Provider Obligations	☐ Handouts ☐ Video ☐ Lecture ☐ Website ☐ Other		
Fire Safety and Prevention	☐ Handouts ☐ Video ☐ Lecture ☐ Website ☐ Other		
Emergency non-medical (evacuation, workplace violence)	☐ Handouts ☐ Video ☐ Lecture ☐ Website ☐ Other		

Online Resources for Required Employee Training

	Website
Emergency Non-Medical Procedures	• https://www.osha.gov/SLTC/emergencypreparedness/index.html
Workplace Violence	• https://www.osha.gov/SLTC/workplaceviolence/index.html
Bloodborne Pathogens (Required annually)	• https://www.osha.gov/SLTC/bloodbornepathogens/index.html
Biohazardous Waste Handling (Required Annually)	• https://www.cdc.gov/infectioncontrol/guidelines/environmental/background/medical-waste.html#i1
Universal Precautions & Infection Control (Required Annually)	• https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html • https://www.cdc.gov/infectioncontrol/guidelines/index.html
Adult & Elder Abuse Certification Course	• https://cdss.ca.gov/MandatedReporting/story.html
Child/Elder/Intimate Partner Violence Prevention & Mandated Reporter Requirements	• https://www.cdc.gov/ViolencePrevention/index.html • https://www.adoc.us/ADOC-enus/assets/File/MandatedReportingRequirementsMRR_ Mandated-Reporting-Requirement.pdf
CA Minor Consent & Confidentiality Laws	• http://teenhealthlaw.org/wp-content/uploads/2019/08/2019CaMinorConsent ConfChartFull.pdf
National CLAS Standards	• https://thinkculturalhealth.hhs.gov/clas/what-is-clas *(Free training go under education and click Behavioral Health and click Begin)*
Patient Confidentiality	• https://www.hhs.gov/hipaa/for-professionals/index.html
Informed Consent	• https://www.hhs.gov/ohrp/regulations-and-policy/guidance/faq/informed- consent/index.html
	Miscellaneous Training
Medication Administration for Non-Licensed Staff	• https://www.mbc.ca.gov/Licensees/Physicians_and_Surgeons/Medical_Assistants/Medical_Assistants_FAQ.aspx
Multi-Dose Medication Vials	• https://www.cdc. gov/injectionsafety/providers/ provider_faqs_multivials.html
	Pediatric Preventive
Anthropometric Measurements	• https://www.cdc.gov/bmi/child-teen-calculator/measure-child-height-weight.html • https://wwwn.cdc.gov/nchs/data/nhanes/2017-2018/manuals/2017_Anthropometry_Procedures_Manual.pdf
Hearing Screening	• https://youtu.be/pU60t2PjrHg?si=vPHQBjWwXplrP_Qt • https://www.ruhealth.org/sites/default/files/PH/CHDP/docs/2023%20CHDP%20Audiometric%20Training%20Materials.pdf
Vision Screening	• https://higherlogicdownload.s3.amazonaws.com/AAPOS/159c8d7c-f577-4c85-bf77-ac8e4f0865bd/UploadedImages/Documents/Pediatric_Vision_Screening_-Bradford_2022.pdf • https://www.ruhealth.org/sites/default/files/PH/CHDP/docs/2023%20Vision%20Training%20Materials.pdf • AAP Nevada Chapter - Practical Aspects of Vision Screening for the Pediatrician https://youtu.be/kcIuMd591Xo?si=iz3QLIGg1VXDsqes
Dental Services	• All Courses- Smiles for Life Oral Health https://www.smilesforlifeoralhealth.org/

SAMPLE

Policy and Procedure

Title: Infection Control Standards, Biohazardous Waste, and Disposition of Patients with Contagious Diseases
Area: Personnel & Infection Control

Infection Control Standards

Universal Precautions

- With the identification of HIV (human immunodeficiency virus) and its mode of transmission, as well as an increase in the incidence of Hepatitis B, the Centers for Disease Control (CDC) now recommends that the precautions taken for bloodborne diseases, i.e. blood/body fluid precautions, be utilized for all patient encounters whenever direct patient contact is involved, regardless of whether or not a bloodborne disease is initially suspected. Due to the necessity for expanding the application of blood/body fluid precautions, this procedure is referred to as "Universal Precautions".
- Universal Precautions means that all blood and body fluids will be treated as infectious, although the special hazards and higher risks of transmission with certain body fluids are recognized. In order to prevent transmission of potentially infectious agents, a consistent approach to managing body substances must be carried out. Universal Precautions are recognized as an integral component of an overall infection control program and will be used in all work activities with any potential for exposure to blood or other body fluids.
- When designing office policies and procedures, consideration must be given to meeting all current and applicable regulations of Cal/OSHA, and the Department of Health Services.
- Any materials that could potentially be contaminated with blood or other human body fluids, including instruments, environmental surfaces, etc. should be considered infectious.
- PCP office staff will prevent cross contamination of infection by the use of proper infection control techniques, appropriate use of clean/sterile supplies and equipment, and provide a safe environment, utilizing infection control procedures and precautions between the following categories of persons:
  - Patients and employees
  - Patients and patients
  - Patients and visitors
  - Employees and employees
  - Employees and visitors
- All new staff must be trained in infection control principles and techniques. Continuous education of staff is important to ensure compliance with standards.

Infection Control Procedures

- Adequate infection control devices and supplies must be available in the patient areas. These include a sink, preferably with 4-6 inch wing tip faucet handles, antibacterial soap, paper towels, and appropriate garbage receptacle, disposable gloves, and sharps container.
- All personnel who have occupational exposure to blood borne pathogens will be offered Hepatitis B vaccine and necessary boosters as per Cal/OSHA requirements. Documentation of vaccine status of declination of vaccine will be kept on record.
- All personnel must wear protective gloves during procedures where contact with potentially contaminated substances is likely.
- All personnel must wear protective eye wear during procedures when it is likely that the eyes may be splashed with potentially contaminated substances.
- All personnel must wear a protective mask during procedures when it is likely that mouth or nose maybe splashed with potentially contaminated substances.
- All personnel must wear a protective, fluid resistant gown during procedures when it is likely that clothes will be contaminated with blood or body fluids.
- Hands must be washed when gloves are removed and after any direct or indirect contact with any blood or body substances.

- Potentially contaminated instruments must be handled carefully wearing gloves designed to withstand cleaning procedures. Instruments, equipment and environmental surfaces must be cleaned with solutions appropriate to the level of contamination and that meet appropriate guidelines. Surfaces must be cleaned with a 10% bleach solution (1:10 solution of household bleach and water). Solution is stable only 24 hours; therefore a fresh solution should be mixed every 24 hours. When mixed and stored in a separate container, the container must be dated, labeled, and discarded after 24 hours. Germicidal solutions must be effective against tuberculosis, hepatitis and HIV.
- A critical instrument (that which has penetrated soft issue, bone, or come in contact with mucous membranes) if not disposable, must be sterilized in a heat or heat pressure sterilizer.
- A touch and splash surface (exposed to the splatter of blood or body fluids or contaminated by treatment personnel) must be immediately disinfected with a 10% bleach solution or germicidal solutions which must be effective against tuberculosis, hepatitis and HIV.
- Use of appropriate housekeeping techniques to prevent cross-contamination.
- Potentially contaminated waste must be disposed of per "handling of Biohazardous Waste" procedures.

Hand Washing

- One of the most effective ways to prevent infection transmission among patients as well as personnel is by hand washing. Thorough hand washing is to be done upon entering and leaving a room. Hand washing is the single most important means of preventing the spread of infection. Hands must always be washed following any contact with a patient, before performing invasive procedures, before taking care of particularly susceptible patients such as those who are severely immuno-compromised or newborn infants, before and after touching wounds, after touching inanimate sources that are likely to be contaminated, such as urine measuring devices or linen.
- Hand washing facilities shall be readily accessible. For routine hand washing, a vigorous rubbing together of all surfaces of soap lathered hands for at least ten seconds, followed by a thorough rinsing under a stream of water is recommended. Bactericidal hand wipes are acceptable. Hand washing or the use of hand wipes should be performed whenever personnel are in doubt about the necessity for doing so.

Designated "Soiled Area" and "Clean Area"

- A "soiled area" and a "clean area" must be designated in the work area where soiled instruments are placed prior to processing for sterilization.

Biohazardous Waste

- All staff members shall be knowledgeable of procedures for handling and disposing of infectious waste. Medical waste, including biohazardous waste, sharps waste and waste which is generated or produced as a result of the diagnosis, treatment or immunization, is handled according to the Medical Waste Management Action which became effective January 1, 1997. Medical waste must be contained separately from other waste. A Hazardous Waste Management hauler who is registered with the State of California must perform the hauling of medical waste. A signed contract with an approved licensed medical waste hauler is to be kept on-site and current at all times. Receipts and/or logs of materials removed by contractors must be maintained for at least two years.
- Biohazardous waste includes, but is not limited to:
    - Cultures from medical and pathological labs.
    - Cultures and stocks of infectious agents from research and industrial labs.
    - Wastes from the production of bacteria, viruses, or the use of spores, discarded live and attenuated vaccines, culture dishes and devices used to transfer, and inoculate and mix cultures.
    - Waste containing any microbiologic specimens sent to lab for analysis.
    - Human surgery specimens or tissues removed at surgery.
    - Waste containing discarded materials contaminated with excretion, exudates, or secretions from humans who are required to be isolated to protect others from highly communicable disease.
    - Blood and body fluids.

Biohazardous Waste Standards

- Biohazardous waste must be consistently handled with universal precautions. Containers used for biohazardous waste must be labeled or color-coded to alert all employees that the containers require compliance with universal precautions.

Biohazardous Waste Handling Procedures

- Protective gloves are to be worn when handling any potentially contaminated waste.
- A cover gown should be worn to protect clothing when it is possible that clothing will be contaminated by waste.
- Masks and/or eye protection should be worn when it is possible that the mucous membranes and/or eyes may be splashed with contaminated waste.
- The area used for the storage of medical waste containers must be secured so as to deny access to unauthorized persons and must be marked with a warning sign on or adjacent to the exterior doors, gates or lids.
- The warning signs, "Caution-Biohazardous Waste Storage Area, unauthorized persons keep out", must be posted and legible.
- Containers holding biohazardous waste must be red and labeled with the standard fluorescent orange or orange-red 'Biohazardous Waste' label or with the biohazardous symbol and word "Biohazard".
- Biohazardous waste must be disposed of in an appropriate container, i.e. sharps in sharps container.
- All biohazardous waste containers will be disposed of according to federal, state and local regulations.

Sharps Waste Handling Procedure

- Sharps waste means any device having acute rigid corners or edges capable of cutting or piercing, including but not limited to hypodermic needles, syringes, blades and needles with attached tubing, broken glass items, such as blood vials contaminated with medical waste.
- Contaminated needles and other contaminated sharps shall not be sheared or purposely broken. Cal/OSHA allows recapping, bending or removal of contaminated needles only when the medical procedure requires it and no alternative is feasible. If such action is required, then it must be done by the use of a mechanical device or a one-handed technique.
- Place all sharps immediately after use into a sharps container, a rigid puncture-resistant container which, when sealed, is leak resistant and cannot be reopened without great difficulty. Sharps containers must be located as close as possible to the area where sharps are used.
- Sharps containers shall not be allowed to be overfilled. Sharps containers must be maintained in an upright position. The lid on a full sharps container, ready for disposal, must fit tightly or be taped closed.
- Label the sharps container with the words "sharps waste" or with the international biohazard symbol and the word "Biohazard". Biohazardous waste must be consistently handled with universal precautions. Containers used for biohazardous waste must be labeled or color-coded to alert all employees that the containers required compliance with universal precautions.
- Security (meaning locked) of portable containers in patient care areas is maintained at all times.

Accidental Needle Sticks

- All personnel who have occupational exposure to blood borne pathogens will be offered Hepatitis B vaccine and necessary boosters as per Cal/OSHA requirements. Documentation of vaccine status or declination of vaccine will be kept on record.
- Medical evaluation and procedures, including the Hepatitis B vaccine and vaccination series and post exposure follow-up, including prophylaxis, must be made available at no cost to the employee, made available to the employee at a reasonable time and place, performed by or under the supervision of a licensed physician or another licensed health care professional, provided according to the recommendations of the U.S. Public Health Service. All laboratory tests must be conducted by an accredited lab at no cost to the employee.
- The source individual's blood shall be tested as soon as feasible and after consent is obtained in order to determine Blood Borne Pathogens infectivity.

- When the source individual is already known to be infected with HBV or HIV, testing for the source individual's known HBV or HIV status need not be repeated.
- Results of the source individual's testing shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.
- Collection and testing of blood for HBV and HIV serological status will comply with the following:
    - The exposed employee's blood shall be collected as soon as feasible and tested after consent is obtained.
    - The employee will be offered the option of having their blood collected for testing for HIV/HBV serological status. The blood sample will be preserved for up to 90 days to allow the employee to decide if the blood should be tested for HIV serological status.
    - All employees who incur an exposure incident will be offered post-exposure evaluation and follow-up in accordance with the Cal/OSHA standards.
    - Training or re-training regarding correct sharps handling and disposal methods will be done.

<u>Disposition of Patients with Contagious Diseases: General Information</u>

- Patients with known or suspected communicable diseases/conditions calling in advance to schedule appointments should be advised to go directly to the receptionist's window upon arrival at the office.
- The receptionist should immediately notify the medical assistant or nurse of the patient's arrival and request that the patient remain at the receptionist's window until the medical assistant/nurse arrives to escort him/her to the exam room.
- Ideally, an alternate entrance that would facilitate direct placement into the designated exam room is preferred.
- Masks covering both the nose and mouth should be worn by all personnel having close contact with the patient. Masks may be worn only once and should be discarded before leaving the room. Gloves and gowns are not indicated.
- Thorough hand washing is to be done upon entering and leaving the room. Discard all disposable waste materials which have or may have come in contact with the patient in the trash container designated for infectious waste.
- Reusable instruments/materials should be bagged and labeled before being sent to the "dirty" utility area for decontamination.
- This exam room must remain closed with no admittance for at least one hour after the patient leaves.
- Disease requiring isolation:
    - Epiglottis, Hemophilus Influenza
    - Measles, Rubeola
    - Meningitis – H Flu
    - Meningococcal Pneumonia
    - Meningococcernia
    - Mumps
    - Pertussis (Whooping Cough)
    - Hemophilus Influenza Pneumonia (in children any age)

*****SAMPLE*****

BLOODBORNE PATHOGENS EXPOSURE PREVENTION POLICY AND PROCEDURE

This sample plan is provided only as a guide to assist in complying with the OSHA Bloodborne Pathogens standard 29 CFR 1910.1030, as adopted by 803 KAR 2:320. It is not intended to supersede the requirements detailed in the standard. Employers should review the standard for particular requirements which are applicable to their situation. It should be noted that this model program does not include provisions for HIV/HBV laboratories and research facilities which are addressed in section (a) of the standard. Employers will need to add information relevant to their particular facility in order to develop an effective, comprehensive exposure control plan. Employers should note that the exposure control plan is expected to be reviewed at least on an annual basis and updated when necessary.

BLOODBORNE PATHOGENS EXPOSURE CONTROL PLAN

Facility Name: _____

Date of Preparation: _____

In accordance with the OSHA Bloodborne Pathogens standard, 29 CFR 1910.1030, as adopted by 803 KAR 2:320, the following exposure control plan has been developed:

1. EXPOSURE DETERMINATION

OSHA requires employers to perform an exposure determination concerning which employees may incur occupational exposure to blood or other potentially infectious materials. The exposure determination is made without regard to the use of personal protective equipment (i.e. employees are considered to be exposed even if they wear personal protective equipment). This exposure determination is required to list all job classifications in which all employees may be expected to incur such occupational exposure, regardless of frequency. At this facility the following job classification(s) are in the category:

_____
_____
_____
_____

In addition, OSHA requires a listing of job classifications in which some employees may have occupational exposure. Since not all the employees in these categories would be expected to incur exposure to blood or to other potentially infectious materials, tasks or procedures that would cause these employees to have occupational exposure are also required to be listed in order to clearly understand which employees in these categories are considered to have occupational exposure.

The job classifications and associated tasks for these categories are as follows:

(The employer could use a checklist as follows:)

JOB CLASSIFICTIONS	TASK/PROCEDURES

2. IMPLEMENTATION SCHEDULE AND METHODOLOGY

OSHA also requires that this plan also include a schedule and method of implementation for the various requirements of the standard. The following complies with this requirement:

COMPLIANCE METHODS

Universal precautions will be observed at this facility in order to prevent contact with blood or other potentially infectious materials. All blood or other potentially infectious material will be considered infectious regardless of the perceived status of the source individual.

Engineering and work practice controls will be utilized to eliminate or minimize exposure to employees at this facility. Where occupational exposure remains after institution of these controls, personal protective equipment shall also be utilized. At this facility the following engineering controls will be utilized: (list controls, such as sharps container, etc.)

_____
_____
_____
_____

The above controls will be examined and maintained on a regular schedule. The schedule for reviewing the effectiveness of the controls is as follows: (list schedule such as daily, once/week, etc. as well as list who has the responsibility to review the effectiveness of the individual controls, such as the supervisor for each department, etc).

Handwashing facilities are also available to the employees who incur exposure to blood or other potentially infectious materials. OSHA requires that these facilities be readily accessible after incurring exposure.

List location of handwashing facilities: (such as patient rooms, procedure areas, etc.) If handwashing facilities are not feasible, the employer is required to provide either an antiseptic cleanser in conjunction with a clean cloth/paper towels or antiseptic towelettes. If these alternatives are used, list the location, tasks, and responsibilities to ensure maintenance and accessibility of these alternatives. Hands are to be washed with soap and running water as soon as feasibly possible.

_____
_____
_____
_____

After removal of personal protective gloves, employees shall wash hands and any other potentially contaminated skin area IMMEDIATELY or as soon as feasibly possible with soap and water.

If employees incur exposure to their skin or mucous membranes then those areas shall be washed or flushed with water as appropriate as soon as feasibly possible following contact.

NEEDLES

Contaminated needles and other contaminated sharps will not be bent, recapped, removed, sheared or purposely broken. OSHA allows an exception to this if the procedure would require that the contaminated needles be recapped or removed and no alternative is feasible and the action is required by the medical procedure. If such action is required than the recapping or removal of the needle must be done by the use of a mechanical device or a one-handed technique. At this facility recapping or removal is only permitted for the following procedures: (List the procedures and also list the mechanical device to be used or alternately if a one-handed technique will be used).

_____
_____
_____
_____

CONTAINERS FOR REUSABLE SHARPS

Contaminated sharps that are reusable are to be placed immediately, or as soon as possible, after use into an appropriate container.

At this facility the sharps containers are puncture resistant, labeled with a biohazard label, and are leak proof. (Employers should list here where sharps containers are located as well as who has responsibility for removing sharps from containers and how often the containers will be checked to remove the sharps).

_____
_____
_____
_____
_____

WORK AREA RESTRICTIONS

In work areas where there is a reasonable likelihood of exposure to blood or other potentially infectious materials, employees are not to eat, drink, apply cosmetics or lip balm, smoke, or handle contact lenses. Food and beverages are not to be kept in refrigerators, freezers, shelves, cabinets, or on counter tops or bench tops where blood or other potentially infectious materials are present.

Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.

All procedures will be conducted in a manner which will minimize splashing, spraying, splattering, and generation of droplets of blood or other potentially infectious materials. Methods which will be employed at this facility to accomplish this goal are:

(List methods, such as covers on centrifuges, usage of dental dams if appropriate, etc).

_____
_____
_____
_____
_____

SPECIMENS

Specimens of blood or other potentially infectious materials will be placed in a container which prevents leakage during the collection, handling, processing, storage, and transport of the specimens.

The container used for this purpose will be labeled or color coded in accordance with the requirements of the OSHA standard.

(Employers should note that the standard provides for an exemption for specimens from the labeling/color coding requirement of the standard provided that the facility utilizes universal precautions in the handling of all specimens and the containers are recognizable as containing specimens. This exemption applies only while the specimens remain in the facility). If the employer chooses to use this exemption then it should be stated below:

_____
_____

Any specimens which could puncture a primary container will be placed within a secondary container which is puncture resistant. (The employer should list here how this will be carried out, e.g. which specimens, if any, could puncture a primary container, which containers can be used as secondary containers and where the secondary containers are located at the facility).

_____
_____
_____

If outside contamination of the primary container occurs, the primary container shall be placed within a secondary container which prevents leakage during the handling, processing, storage, transport, or shipping of the specimen.

CONTAMINATED EQUIPMENT

Equipment which has become contaminated with blood or other potentially infectious materials shall be examined prior to servicing or shipping and shall be decontaminated as necessary unless the decontamination of the equipment is not feasible. (Employers should list here any equipment which it is felt can not be decontaminated prior to servicing).

_____
_____
_____
_____

PERSONAL PROTECTIVE EQUIPMENT

All personal protective equipment used at this facility will be provided without cost to employees. Personal protective equipment will be chosen based on the anticipated exposure to blood or other potentially infectious materials. The protective equipment will be considered appropriate only if it does not permit blood or other potentially infectious materials to pass through or reach the employees' clothing, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.

Protective clothing will be provided to employees in the following manner:

(List how the clothing will be provided to employees, e.g. who has responsibility for distribution, etc. and also list which procedures would require the protective clothing and the type of protection required, this could also be listed as an appendix to this program).

The employer could use a checklist as follows:

Personal Protective Equipment	**Task**
Gloves	
Lab Coats	
Face Shield	
Clinic Jacket	
Protective Eye Wear (with solid side shield)	
Surgical Gown	
Shoe Covers	
Utility Covers	
Examination Gloves	
Other PPE (List)	

All personal protective equipment will be cleaned, laundered, and disposed of by the employer at no cost to the employees. All repairs and replacements will be made by the employer at no cost to employees.

All garments which are penetrated by blood shall be removed immediately or as soon as feasibly possible. All personal protective equipment will be removed prior to leaving the work area. The following protocol has been developed to facilitate leaving the equipment at the work area: (List where employees are expected to place the personal protective equipment upon leaving the work area, and other protocols, etc.)

_____

_____

_____

Gloves shall be worn where it is reasonably anticipated that employees will have hand contact with blood, other potentially infectious materials, non-intact skin, and mucous membranes.

Gloves will be available from (state location and/or person who will be responsible for distribution of gloves).

_____
_____
_____

Gloves will be used for the following procedures:

_____
_____
_____

Disposable gloves used at this facility are not to be washed or decontaminated for re-use and are to be replaced as soon as practical when they become contaminated or as soon as feasibly possible of they are torn, punctured, or when their ability to function as a barrier is compromised. Utility gloves may be decontaminated for re-use provided that the integrity of the glove is not compromised. Utility gloves will be discarded if they are cracked, peeling, torn, punctured, or exhibits other signs of deterioration or when their ability to function as a barrier is compromised.

Masks in combination with eye protection devices, such as goggles or glasses with solid state shield, or chin length face shields, are required to be worn whenever splashes, spray, splatter, or droplets of blood or other potentially infectious materials may be generated and eye, nose, or mouth contamination can reasonably be anticipated. Situations at this facility which would require such protection are as follows:

_____
_____
_____

This OSHA standard also requires appropriate protective clothing to be used, such as lab coats, gowns, aprons, clinic jackets, or similar outer garments. The following situations require that such protective clothing be utilized:

_____
_____
_____

This facility will be cleaned and decontaminated according to the following schedule: (List area and schedule)

_____
_____
_____

Decontamination will be accomplished by utilizing the following materials: (List the materials which will be utilized, such as bleach solutions or EPA registered germicides)

_____
_____

All contaminated work surfaces will be decontaminated after completion of procedures and immediately or as soon as feasibly possible after any spillage of blood or other potentially infectious materials, as well as at the end of the work shift if the surface may have become contaminated since the last cleaning. (Employers should add in any

information concerning the usage of protective coverings, such as plastic wrap which they may be using to assist in keeping surfaces free of contamination).

_____
_____
_____

All bins, pails, cans and similar receptacles shall be inspected and decontaminated on a regularly scheduled basis (list frequency and by whom).

_____
_____

Any broken glassware which may be contaminated will not be picked up directly with other hands. The following procedures will be used:

_____
_____

REGULATED WASTE DISPOSAL

All contaminated sharps shall be discarded as soon as feasibly possible in sharps containers which are located in the facility. Sharps containers are located in (specify locations of sharps containers).

_____
_____

Regulated waste other than sharps shall be placed in appropriated containers. Such containers are located in (specify locations of containers).

_____
_____

LAUNDRY PROCEDURES

Laundry contaminated with blood or other potentially infectious materials will be handled as little as possible. Such laundry will be placed in appropriately marked bags at the location where it was used. Such laundry will not be sorted or rinsed in the area of use.

All employees who handle contaminated laundry will utilize personal protective equipment to prevent contact with blood or other potentially infectious materials.

Laundry at this facility will be cleaned at:

_____

(Employers should note here if the laundry is being sent off site. If the laundry is being sent off site, then the laundry service accepting the laundry is to be notified, in accordance with section (d) of the standard).

HEPATITIS B VACCINE

All employees who have been identified as having exposure to blood or other potentially infectious materials will be offered to Hepatitis B vaccine, at no cost to the employee. The vaccine will be offered within 10 working days of their initial assignment to work involving the potential for occupational exposure to blood or other potentially infectious

materials unless the employee has previously had the vaccine or who wish to submit to antibody testing which shows the employee to have sufficient immunity.

Employees who decline the Hepatitis B vaccine will sign a waiver which uses the working in Appendix A of the OSHA standard.

Employees who initially decline the vaccine but who later wish to have it may then have the vaccine provided at no cost. (Employers should list here who has responsibility for assuring that the vaccine is offered, the waivers are signed, etc. Also, the employer should list who will administer the vaccine).

_____
_____
_____
_____

POST-EXPOSURE EVALUATION AND FOLLOW-UP

When the employee incurs an exposure incident, it should be reported to (list who has responsibility to maintain records of exposure incidents):

_____

All employees who incur an exposure incident will be offered post-exposure evaluation and follow-up in accordance with the OSHA standard.

This follow-up will include the following:

- Documentation of the route of exposure and the circumstances related to the incident.
- If possible, the identification of the source individual and if possible, the status of the source individual will be tested (after consent is obtained) for HIV/HBV infectivity.
- Results of testing of the source individual will be made available to the exposed employee with the exposed employee informed about the applicable laws and regulations concerning disclosure of the identity and infectivity of the source individual. (Employers may need to modify this provision in accordance with applicable local laws on this subject. Modifications should be listed here:

  _____
  _____
  _____
  _____

- The employee will be offered the option of having their blood collected for testing of the employee HIV/HBV serological status. The blood sample will be preserved for up to 90 days to allow the employee to decide if the blood should be tested for HIV serological status. However, if the employee decides prior to that time that testing will or will not be conducted then the appropriate action can be taken and the blood sample discarded.
- The employee will be offered post exposure prophylaxis in accordance with the current recommendations of the U.S. Public Health Service. These recommendations are currently as follows: (These recommendations may be listed as an appendix to the plan)

_____
_____
_____
_____
_____

- The employee will be given appropriate counseling concerning precautions to take during the period after the exposure incident. The employee will also be given information on what potential illnesses to be alert for and to report any related experiences to appropriate personnel.
- The following person(s) has been designated to assure that the policy outlined here is effectively carried out as well as to maintain records related to this policy:

  _____
  _____
  _____
  _____

INTERACTION WITH HEALTH CARE PREFESSIONALS

A written opinion shall be obtained from the health care professional who evaluates employees of this facility. Written opinions will be obtained in the following instances:

1) When the employee is sent to obtain the Hepatitis B vaccine.

2) Whenever the employee is sent to a health care professional following an exposure incident.

Health care professionals shall be instructed to limit their opinions to:

1) Whether the Hepatitis B vaccine is indicated and if the employee has received the vaccine, or for evaluation following an incident.

2) That the employee has been informed of the results of the evaluation, and

3) That the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials. (Note that the written opinion to the employer is not to reference any personal medical information).

TRAINING

Training for all employees will be conducted prior to initial assignment to tasks where occupational exposure may occur. Training will be conducted in the following manner:

Training for employees will include the following an explanation of:

1) The OSHA standard for Bloodborne Pathogens

2) Epidemiology and symptomatology of bloodborne diseases

3) Modes of transmission of bloodborne pathogens

4) This Exposure Control Plan, i.e. points of the plan, lines of responsibility, how the plan will be implemented, etc.)

5) Procedures which might cause exposure to blood or other potentially infectious materials at this facility

6) Control methods which will be used at the facility to control exposure to blood or other potentially infectious materials.

7) Personal protective equipment available at this facility and who should be contacted concerning

8) Post Exposure evaluation and follow-up

9) Signs and Labels used at the facility

10) Hepatitis B vaccine program at the facility

RECORDKEEPING

All records required by the OSHA standard will be maintained by: (Insert name or department responsible for maintaining records)

_____

DATES

All provisions required by the standard will be implemented by: (Insert date for implementation of the provisions of the standard)

_____
_____

(Employers should list here if training will be conducted using videotapes, written materials, etc. Also the employer should indicate who is responsible for conducting the training).

_____
_____

All employees will receive annual refresher training. (Note that this training is to be conducted within one year of the employee's previous training).

The outline for the training material is located (list where the training materials are located).

_____
_____

SAMPLE*

OATH OF PATIENT CONFIDENTIALITY

- I agree not to divulge any information obtained during the course of my activities regarding patients to **any** non-employee.
- Such information should never be disclosed either directly or indirectly, in verbal or written form, with or in the presence of individuals outside this office.
- I understand that information regarding patients may **only** be released to staff employees who have a designated need to know the information in the services of the patient.
- I also understand that failure to comply with this policy will be grounds for immediate termination.

I recognize that the unauthorized release of confidential information may make me subject to civil action under provisions of the Welfare and Institutions Code and the Insurance Code Information and Privacy Protection Act.

EMPLOYEE:

Print Name	Signature	Date

Outside Housekeeping Service

Print Name	Signature	Date

Other : i.e. Students

Print Name	Signature	Date

16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

A. Member Grievance and Appeals Resolution

1. Member Rights and Options

***APPLIES TO*:**

A. This policy applies to all IEHP Medi-Cal Members.

***POLICY*:**

A. IEHP informs Members of their rights and options in accordance with state and federal regulatory guidelines and National Committee for Quality Assurance (NCQA) standards. This information is provided at enrollment and annually thereafter through the IEHP Medi-Cal Member Handbook/Evidence of Coverage (EOC), as well as during the grievance and appeal resolution process.[1]

DEFINITION:

A. Delegate – For the purpose of this policy, this is defined as a Physician, medical group, Health Plan, IPA, or any contracted organization delegated to provide services on behalf of IEHP.

PURPOSE:

A. To define the rights and options available to Members filing a grievance or appeal.

B. To ensure there is no discrimination against a Member, including cancellation of the contract, solely on the grounds of filing a grievance or appeal.[2]

PROCEDURES:

A. **Grievances:** Members, their authorized representative or a Provider acting on behalf of a Member and with the Member's consent, may file a grievance at any time following any incident or action that is the subject of the Member's dissatisfaction.[3] Grievances may be filed with IEHP by phone, mail, fax, in person, online through IEHP's website at www.iehp.org, or with the assistance of the involved Provider.[4,5,6,7]

Members have the right to personally register a grievance, or designate, either in writing or

[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 4, Written Member Information.
[2] DHCS All Plan Letter (APL) 17-006 Supersedes APL 04-006 and 05-005 and Policy Letter (PL) 09-006, "Grievance and Appeal Requirements and Revised Notice Templates and 'Your Rights' Attachments".
[3] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 2, Grievance Process.
[4] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 1, Members' Rights and Responsibilities.
[5] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provisions 1, Member Grievance and Appeal System.
[6] DHCS APL 17-006.
[7] Title 42, Code of Federal Regulations (CFR) § 438.402.

verbally that a relative, a representative, Practitioner, Provider or attorney will represent them during the grievance process. In addition, if the Member is a minor, or is incompetent or incapacitated, a grievance may be registered on behalf of the Member by the parent, guardian, conservator, relative, or other designee of the Member, as appropriate. IEHP recognizes the term "relative" to include a parent, stepparent, spouse, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the Member.[8] Please see Policy 16A1, "Member Grievance Resolution Process" for more information.

B. **Appeals:** Members, their authorized representative or a Provider acting on behalf of a Member and with Member's written consent, have up to sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination (NABD) to file an appeal with IEHP either orally or in writing.[9,10] Members have the right to request continuation of benefits during an appeal.[11] Please see Policy 16A2, "Member Appeals Resolution Process" for more information.

C. **Confidentiality:** Members have the right to confidentiality of medical information.[12] Members have the right to file a grievance with the IEHP Chief Compliance Officer, the California Department of Health Care Services (DHCS) Privacy Officer, or the Department of Health and Human Services (DHHS) Office of Civil Rights if the Member believes their right to confidentiality has been violated (HIPAA violation). This information is contained in the IEHP Notice of Privacy Practices.

D. **Submission of Additional Information:** Members have the right to submit written comments, documents or other information relating to their grievance.[13] This information is relayed to the Member during the triage of the grievance by IEHP and in writing through the denial-related grievance (appeal) acknowledgment letter.

E. **Discrimination:** All Members have the right to receive access to all covered services without restriction based on race, color, ethnicity, ethnic group identification, national origin, ancestry, language, religion, sex, age, mental or physical disability or medical condition, gender, gender identity, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic

[8] Knox-Keene Health Care Service Plan Act of 1975, § 1368.
[9] DHCS APL 17-006.
[10] 42 CFR § 438.402.
[11] National Committee for Quality Assurance (NCQA), 2020 Health Plan Standards and Guidelines, UM 8, Element A, Factor 16.
[12] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 1, Members' Rights and Responsibilities.
[13] NCQA, 2020 HP Standards and Guidelines, UM 8, Element A, Factor 4.

information, marital status, or source of payment.[14,15,16,17,18] IEHP also assures that there is no discrimination against a Member on the grounds that the complainant filed a grievance.[19,20]

Any grievance alleging discrimination against the Member must be filed by email, fax to (909) 890-5748, phone, web, or in person to IEHP immediately. Discrimination grievances are resolved in accordance with the Section 1557 of the Affordable Care Act (ACA). All substantiated cases alleging discrimination against Members or eligible beneficiaries are forwarded to DHCS for review.[21] Please see Policy 9H3, "Cultural and Linguistic Services – Non-Discrimination."

F. **Change of Provider:** Members have the right to request a change of their Primary Care Provider (PCP) at any time.[22]

G. **Right to Disenroll:** Members have the right to disenroll from IEHP at any time without giving a reason.[23]

H. **Linguistic Needs:** IEHP Members have the right to file a grievance if their linguistic needs are not met when seeking medical care. [24]

I. **Request for Assistance:** Members have the right to contact DMHC for assistance and/or to request an Independent Medical Review (IMR).

J. Members are informed of the following rights and options during the Appeals Resolution Process:[25]

1. The Medi-Cal Fair Hearing

a. Medi-Cal Members, their authorized representative or a Provider acting on behalf of the Members and with the Member's written consent, or representative of a deceased Member's estate have the right to request a Medi-Cal Fair Hearing orally or in writing after IEHP completes review of appeal and issues a Notice of Appeal Resolution

[14] 42 CFR § 422.110(a).
[15] 45 CFR Part 92.
[16] California Welfare and Institutions Code (Welf. & Inst. Code) § 14029.91.
[17] CA Government Code (Gov. Code) § 11135(a).
[18] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 2, Provision 28, Discrimination Prohibition.
[19] DHCS APL 17-006.
[20] Title 28, California Code of Regulations (CCR) § 1300.68(b)(8).
[21] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 2, Provision 28, Discrimination Prohibitions.
[22] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 1, Members' Rights and Responsibilities
[23] Ibid.
[24] DHCS PL 99-03, "Linguistic Services".
[25] NCQA, 2020 HP Standards and Guidelines, UM 8, Element A, Factor 10.

(NAR).[26,27,28]

c. Medi-Cal Members have the right to continued medical assistance and benefits, including continuation of services previously authorized, pending a Fair Hearing decision if the Member appeals in writing to the Department of Health Care Services for a hearing:

1) within ten (10) calendar days of the mailing or personal delivery of the NAR to reduce or terminate authorization for a medical service; or

2) before the effective date of action.

2. The Right to Contact DMHC

a. The following statement is included in all Member grievance correspondence:[29]

"If you want an IMR, you must ask for one within one hundred-eighty (180) calendar days from the date of this "Notice of Appeal Resolution" letter. The paragraph below will provide you with information on how to request an IMR. Note that the term "grievance" is talking about both "complaints" and "appeals."

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-440-4347** or **TTY 1-800-718-4347** and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than thirty (30) calendar days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Website **(http://www.hmohelp.ca.gov)** has complaint forms, IMR application forms, and instructions online."

b. DMHC may require Members to participate in IEHP's Grievance Resolution Process for up to thirty (30) calendar days prior to pursuing a grievance with DMHC, unless it

[26] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 7, State Fair Hearings and Independent Medical Reviews.
[27] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 16, Provision 3, Disenrollment
[28] DHCS APL 17-006.
[29] KKA, § 1368.02(b).

is determined that an earlier review is warranted.

3. Expedited Review

   a. Members have the right to an expedited review and resolution of their urgent grievance within seventy-two (72) hours, if their medical condition involves an imminent and serious threat to the health of the patient, including but not limited to, severe pain, and potential loss of life, limb, or major bodily function.[30,31,32] See Policy 16A2, "Grievance Resolution Process - Member Urgent Medical Grievances" for more information.

4. Voluntary Mediation[33]

   a. Members or their authorized representative may request voluntary mediation with IEHP prior to exercising the right to submit a grievance to DMHC. The use of mediation services does not preclude the right of the Member to submit a grievance to DMHC upon completion of mediation.

   b. In order to initiate mediation, the Member or his/her authorized representative and IEHP must voluntarily agree to mediation.

   c. Expenses for mediation are borne equally by IEHP and the Member.

5. Independent Medical Review (IMR)

   a. A Member may request an IMR of disputed health care services from DMHC if he/she believes that health care services have been improperly denied or partially approved (modified) by IEHP or one of its Delegates, in whole or in part because the service is not medically necessary, or related to experimental and investigational therapies.[34] A disputed health care service is any health care service eligible for coverage and payment under the subscriber contract that has been denied, partially approved (modified), or terminated by IEHP or its contracting Providers, in whole or in part because the service is not medically necessary.[35]

      1) Members whose appeal requires expedited review shall not be required to participate in the IEHP's Internal Grievance process for more than three (3) calendar days before applying for an IMR.

      2) If DMHC determines that Member is not eligible for an IMR, the Member's case will be reviewed through DMHC's consumer complaint process.

[30] KKA, § 1368.015.
[31] 28 CCR § 1300.68.01(a).
[32] DHCS APL 17-006.
[33] KKA, § 1368.
[34] CA Health & Saf. Code § 1374.30(i).
[35] KKA, § 1374.30.

3) Members may not request an IMR if a State Fair Hearing has already been held on the issue.

b. Members may apply for an IMR without first participating in IEHP's internal Appeal process in extraordinary and compelling cases, as determined by DMHC, and in cases where Member's request for an experimental treatment was denied. Members are notified in writing of the opportunity to request an IMR of a decision denying an experimental therapy within five (5) business days of the decision to deny coverage.

c. Members may request an IMR when the following criteria has been met: [36]

1) The Member's Doctor recommended a health care service as medically necessary;

2) The Member has received urgent care or emergency services that a Provider determined was medically necessary;

3) The Member has seen a Provider within the IEHP network for the diagnosis or treatment of the medical condition for which the Member seeks IMR. The Provider may be an out-of-network Provider when DMHC finds that the Member's decision to secure services outside IEHP's network was reasonable under the circumstances and the disputed health care services were a covered benefit under the terms and conditions of IEHP's contract;

4) The disputed health care service has been denied, partially approved (modified) or terminated by IEHP or one of its Delegates, based in whole or in part on a decision that the health care service is not medically necessary; or

5) The Member has filed a grievance with IEHP and IEHP has determined to agree with the denial decision or the grievance remains unresolved for thirty (30) calendar days. If the grievance requires expedited review, the Member may immediately submit the request for IMR to DMHC.

d. The Member may apply to DMHC for an IMR within six (6) months after an appeal was filed with IEHP and the disputed decision is upheld, in whole or in part, that the service is not medically necessary or the case remains unresolved more than thirty (30) calendar days. If the case requires expedited review, Members are not required to file an appeal with IEHP prior to submitting the request for an IMR with DMHC.

e. Members may contact IEHP for additional information regarding how to request an IMR or to request an IMR application form at (800) 440-4347 or TTY (800) 718-4347.

L. **Access to Grievance Documents:** For denial-related appeals, Members have the right to obtain access to and copies of relevant grievance documents upon request and at no cost to

[36] KKA, § 1374.30.

them by contacting Member Services at (800) 440-4347.[37] This information is included in the NAR and grievance resolution letter mailed to the Member. IEHP maintains electronic copies of medical records for ten (10) years.[38,39]

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2021

[37] NCQA, 2020 Health Plan Standards and Guidelines, UM 8, Element A, Factor 12.
[38] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 2, Provision 19, Audit.
[39] KKA, § 1300.68.

16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

A. Member Grievance and Appeals Resolution
   1. Member Rights and Options

10. MEDICAL CARE STANDARDS

N. Mandatory Child Abuse and Neglect Reporting

APPLIES TO:

A. This policy applies to all Mandated Reporters who treat or have contact with IEHP Medi-Cal Members.

POLICY:

A. Primary Care Physicians (PCPs) are responsible for the overall health care of assigned Members including the identification and reporting of suspected child abuse or neglect cases.

B. PCPs are Mandated Reporters according to Penal Code Section 11165.7 and as such they are responsible for directly informing Child Protective Services within their respective county, of identified or suspected abuse or neglect cases and filing reports with appropriate county agencies.

C. Other Mandated Reporters, who are also responsible to directly report identified or suspected child abuse or neglect include IEHP professional staff and:

1. Medical, Dental and Hospital Personnel
2. Mental Health Professionals and Counselors
3. Social Service Personnel

D. IEHP adopts the definition of child abuse/neglect from the California Child Abuse and Neglect Reporting Act: physical injury or death inflicted by other than accidental means upon a child by another person, sexual abuse, neglect, the willful harming or injuring of a child or the endangering of the person or health of a child, and unlawful corporal punishment or injury. For the full definition of "child abuse or neglect," see California Penal Code Section 11165.6.

E. Mandated Reporters, will report identified or suspected abuse or neglect such as:

1. A minor who is physically injured by other than accidental means.
2. A minor who is subjected to willful cruelty or unjustifiable punishment.
3. A minor who is abused or exploited sexually.
4. A minor who is neglected by a parent or caretaker who fails to provide adequate food, clothing, shelter, medical care or supervision.

PROCEDURES:

Identification of Suspected Abuse or Neglect Cases

A. At the health plan level, Providers, care managers, and UM personnel are in a position to identify and report incidents of potential child abuse or neglect. Any obligation to

investigate the particulars of any case rests with Child Protective Services. This allows Mandated Reporters to act based only upon clinical suspicion, without being constrained by the need to investigate or to cast judgment.

B. Health care givers must be alert for signs of possible child abuse or neglect including, but not limited to, the following signs and symptoms:

1. Evidence of malnutrition, starvation, dehydration, failure to thrive;
2. Chronic neglect;
3. Sexual assault;
4. Exposure to controlled substances, street drugs, or alcohol;
5. Conflicting or inconsistent accounts of incidents and injuries;
6. Depression not responding to appropriate therapy or characterized by suicidal thoughts;
7. Shaken baby syndrome;
8. Blunt force trauma;
9. Infection due to lack of medical treatment;
10. A series of accidents, bruises, or fractures over time;
11. Unexplained illness or injury;
12. Poor or worsening school or work performance not otherwise explained;
13. On office visit, the presence of physical findings of trauma inconsistent with a Member's stated history, or inconsistent with the parent's, caregiver's, or guardian's history. Examples include a stated mechanism of injury not consistent with a child's developmental age (e.g., a child who could not have rolled off a bed); and
14. On office visit, the presence of behavioral or emotional clues pointing toward possible abuse or neglect. These may include excessive hostility between a Member and his/her parent or caregiver; excessively avoidant, sullen, fearful, submissive, or anxious behaviors on the part of the Member; or sexually inappropriate, explicit, or familiar behavior on the part of the Member during the office visit.

C. In addition, Mandated Reporters have a variety of further information sources for the identification of child abuse or neglect cases including the following:

1. Request by an Emergency Room for authorization to treat an illness or injury of suspicious or questionable nature;
2. Request by an Urgent Care Center for authorization to treat an illness or injury of suspicious or questionable nature;
3. Hospitalization of a Member for suspicious trauma, illness, or injury;

4. Office visits with Pediatricians, Primary Care Physicians (PCPs), and other health care Providers that reveal unusual physical or emotional findings;
5. Abuse cases identified during the UM or CM process;
6. Requests for assistance received by Member Services from victims of abuse; and
7. Calls to the twenty-four (24) Hour Nurse Advice Line from victims of abuse.

Reporting Suspected Abuse or Neglect Cases

A. Mandated Reporters are responsible for telephoning reports of suspected child abuse or neglect and filing additional report(s) with appropriate agencies.
   1. The telephone report will include the following:
      a. Name, title, and daytime number of reporting party, agency name and address, and date of report.
      b. Name, address, age and present location of minor.
      c. Any information that led the reporting party to suspect that abuse has occurred.
      d. Nature and extent of the minor's injury and condition, if known.
      e. The date and time of incident.
      f. Names and addresses of parents or legal guardians.
      g. Any other information requested by the child protective agency.

Riverside	**San Bernardino**
Child Abuse:	Child Abuse:
Department of Public Social Services	Department of Public Social Services
Child Services Division	Children and Family Services
(800) 442-4918 (24 hours)	(800) 827-8724 (24 hours)

Other Related Responsibilities

A. IEHP and its Delegated IPAs are responsible for educating their contracted PCPs of the procedures for reporting abuse or neglect cases.
B. IEHP and its Delegated IPAs are responsible for case managing abuse or neglect cases and verifying that reporting has occurred.
C. IEHP and its Delegated IPAs are responsible for documenting abuse or neglect cases on the monthly Case Management Log (See Attachment, "Monthly Care Management Log" in Section 25).

REFERENCES:

10. MEDICAL CARE STANDARDS

N. Mandatory Child Abuse and Neglect Reporting

A. California Penal Code §11165.6.

B. California Penal Code §11165.7.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	April 1, 2012
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2020

SAMPLE

SUBJECT: Reporting Domestic Violence
PURPOSE: To establish a standardized process for diagnosis and reporting of suspected domestic violence.
POLICY: It is the policy of _____ (IPA/MD NAME) to ensure that suspected domestic violence cases are recognized and followed up by telephone and written documentation.

DOMESTIC VIOLENCE

Responsibility:
It is required that when a case of domestic violence is observed by a health care practitioner within the scope of his/her employment it will be reported by telephone and followed up with a written report to a local law enforcement agency within two working days of receiving information regarding the injured person.

Procedure:

1. **Guidelines for Assessment**
   A. The healthcare practitioner should identify any symptoms or signs of abuse and report this information to the proper authorities. The possibility of assault should be considered if a patient's explanation of an injury does not seem plausible or when there has been a delay in seeking medical attention. There are certain types of injuries and/or behaviors, which are commonly associated with abuse. The injuries listed below may be indicative of abuse; however, an overall assessment of the individual may need to be done to produce conclusive findings.
      1) Minor lacerations, contusions, abrasions, fractures or sprains.
      2) Injuries to the head, neck, chest, breasts, or abdomen.
      3) Injuries during pregnancy, such as spontaneous abortions.
      4) Multiple injury sites.
      5) Chronic or repeated injuries.
      6) Medical problems which indicate chronic or psychogenic pain.
      7) Physical symptoms related to stress, anxiety disorders or depression.
      8) Chronic diseases such as asthma, seizures, arthritis, etc.
      9) Multiple gynecological problems.
      10) Frequent use of prescribed tranquilizers or pain medications.
      11) Psychiatric symptoms such as panic attacks, substance abuse, inability to cope, feelings of isolation, suicidal tendencies.
      12) Behavioral problems such as an appearance of fright, shame or embarrassment.
2. **Documentation of Abuse**
   A. Well documented medical records must be maintained by the health care practitioner and should include the following information:
      1) The name of the injured person.
      2) The location of the injured person.
      3) The extent and character of the injuries.
      4) The name or identity of the alleged abuser.
      5) A description of the abusive event or description of the major complaints in the patient's own words whenever possible.
      6) The medical and relevant social history of the injured person.
      7) A map of the location of the injuries on the victim's body documented at the time of the health care service.
3. **Reporting**
   A. A report of abuse must be made by telephone as soon as practically possible and be followed up with a written report to a local law enforcement agency within two working days of receiving information regarding the injured person.
   B. Regardless of the seriousness of the injury, a report must be made if it is obvious the injury is current and caused by physical force prohibited under the Penal Code.
   C. In the case of spousal rape even though there may be no injury, a report must be made.
4. **Immunity**
   A. Individuals who are required to report domestic violence are immune from civil and criminal liability for reports of known or suspected abuse.

B. Penalties
   A. Failure to report domestic violence is a misdemeanor and is punishable by imprisonment in the county jail for up to six months or by a fine of up to $1000.00 or both.

10. MEDICAL CARE STANDARDS

M. Mandatory Elder or Dependent Adult Abuse Reporting

APPLIES TO:

A. This policy applies to Mandated Reporters who treat or have contact with IEHP Medi-Cal Members.

DEFINITIONS:

A. **Abuse** – Physical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering of an Elder or Dependent Adult. Abuse is also the deprivation to an Elder or Dependent Adult by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering.

1. **Abandonment** – the desertion or willful forsaking of an Elder or a Dependent Adult by anyone having care of custody of that person under circumstances in which a reasonable person would continue to provide care and custody.
2. **Abduction –** the removal from this state and/or the restraint from returning to this state, of any Elder or Dependent Adult who does not have the capacity to consent to such removal and/or restraint from returning. This also applies to the removal or restraint of any conservatee without the consent of the conservator or the court.
3. **Financial Abuse** – the taking or assistance in taking real or personal property of an Elder or Dependent Adult by undue influence, or for a wrongful use or intent to defraud the Elder or Dependent Adult.
4. **Isolation** – acts intentionally committed to prevent an Elder or Dependent Adult from receiving mail, telephone calls, and callers/visitors (when that is contrary to the wishes of the Elder or Dependent Adult). These activities will not constitute isolation if performed pursuant to a physician and surgeon's instructions, who is caring for the Elder or Dependent Adult at the time, or if performed in response to a reasonably perceived threat of danger to property or physical safety.
5. **Neglect** – the negligent failure of any person having the care or custody of an Elder or a Dependent Adult to exercise a reasonable degree of care. This includes, but is not limited to, the failure to assist in personal hygiene; provide food, clothing, or shelter; provide medical care for physical and mental health needs; failure to protect from health and safety hazards; and failure to prevent malnutrition or dehydration. Neglect includes self-neglect, which is the Elder or Dependent Adult's inability to satisfy the aforementioned needs for himself or herself.
6. **Physical Abuse** – this includes but is not limited to, assault, battery, unreasonable physical constraint, prolonged/continual deprivation of food or water, sexual assault or battery, rape, incest, sodomy, oral copulation, sexual penetration, lewd or lascivious acts; or the use of physical or chemical restraint or psychotropic medication for punishment, for a period beyond that which was ordered by a physician and surgeon

providing care, or for any purpose not authorized by the physician and surgeon.

B. **Dependent Adult** – any person between the ages of 18 and 64 years who resides in this state and who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights.

C. **Elder** – any person residing in this state, 65 years or older.

D. **Mandated Reporter** – an individual who is required by law to report identified or suspected Elder/Dependent Adult abuse. Such individuals include any person who has assumed full or intermittent responsibility for care or custody of an Elder or Dependent Adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for Elder or Dependent Adults, or any Elder or Dependent Adult care custodian, health Provider, clergy Member, or employee of a county adult protective services agency or a local law enforcement agency.

E. **Ombudsman** – the State Long-Term Care Ombudsman, local ombudsman coordinators, and other persons currently certified as ombudsmen by the Department of Aging.

F. **Serious Bodily Injury** – an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ, or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation.

POLICY:

A. Any Mandated Reporter who, in his or her professional capacity, or within the scope of his/her employment, has observed or has knowledge of an incident that reasonably appears to be Abuse, is required by law to directly inform appropriate county agencies by telephone immediately or as soon as practicably possible. An additional written report shall also be submitted to the appropriate agency(ies) within two (2) working days.[1]

B. Mandated Reporters include, but are not limited to: PCPs, Specialists, nurses, and IEHP professional staff (i.e. Providers, care managers, and UM personnel), who treat and/or provide assistance in the delivery of health care services to IEHP Members.

C. **Exceptions**: Physicians and Surgeons, Registered Nurses, and Psychotherapists (as defined in Section 1010 of the Evidence Code) are NOT required to report incidents of Elder/Dependent Adult Abuse when **all** of the following exist:[2]

1. The Mandated Reporter has been informed by an Elder/Dependent Adult that he or she has experienced Abuse; and

2. The Mandated Reporter is not aware of any independent evidence that corroborates the statement that the Abuse has occurred; and

[1] Welfare & Institutions Code § 15630.
[2] Welfare & Institutions Code § 15630.

3. The Elder/Dependent Adult had been diagnosed with a mental illness or dementia; and
4. In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist reasonably believes that the Abuse did not occur.

PROCEDURES:

Identification of Suspected Abuse

A. Health Care Providers and caregivers must be alert for signs of possible Elder/Dependent Adult Abuse including, but not limited to, the following signs and symptoms:
   1. Evidence of malnutrition, starvation, dehydration;
   2. Chronic Neglect;
   3. Sexual assault;
   4. Evidence of financial misappropriation or theft from an Elder/Dependent Adult;
   5. Conflicting or inconsistent accounts of incidents and injuries;
   6. Depression, not responding to appropriate therapy, or characterized by suicidal thoughts;
   7. Blunt force trauma that is not consistent with a fall;
   8. Infection due to lack of medical treatment;
   9. A series of accidents, bruises, or fractures over time;
   10. Unexplained illness or injury;
   11. On office visit, the presence of physical findings of trauma inconsistent with a Member's stated history, or inconsistent with the caregiver's history. Examples include a stated mechanism of injury not consistent with an Elder/Dependent Adult's functional capabilities; and/or
   12. On office visit, the presence of behavioral or emotional clues pointing toward possible Abuse. These may include excessive hostility between a Member and his/her caregiver; excessively avoidant, sullen, fearful, submissive, or anxious behaviors on the part of the Member.

B. In addition, Mandated Reporters have a variety of further information sources for the identification of Elder/Dependent Adult Abuse cases, including the following (when access to such information is available to the Mandated Reporter, and not otherwise prohibited by state or federal law):
   1. Request by an Emergency Room for authorization to treat an illness or injury of suspicious or questionable nature;

2. Request by an Urgent Care Center for authorization to treat an illness or injury of suspicious or questionable nature;
3. Hospitalization of a Member for suspicious trauma, illness, or injury;
4. Office visits with Primary Care Physicians (PCPs), and other health care Providers that reveal unusual physical or emotional findings;
5. Abuse cases identified during the UM or CM process;
6. Requests for assistance received by Member Services from victims of Abuse; and/or
7. Calls to the twenty-four (24) Hour Nurse Advice Line from potential victims of Abuse.

C. Any obligation to investigate the particulars of any case rests with Adult Protective Services. This allows Mandated Reporters to act based only upon clinical suspicion, without being constrained by the need to investigate or to cast judgment.

Reporting of Suspected Abuse

A. **Suspected or Alleged Physical Abuse in a Long Term Care Facility**

1. **Please note**: this section relates to reporting suspected physical abuse which occurred in a long-term care facility but **not** a state mental health hospital or a state development center.
2. If the suspected physical abuse results in serious bodily injury:
   a. A telephone report shall be made to the local law enforcement agency, within two (2) hours of the Mandated Reporter identifying/suspecting the Physical Abuse; and
   b. A written report shall be made to the local Ombudsman, the corresponding licensing agency, and the local law enforcement agency within two (2) hours of the Mandated Reporter identifying/suspecting the Physical Abuse.
3. If the suspected Physical Abuse does **not** result in Serious Bodily Injury:
   a. A telephone report shall be made to the local law enforcement agency within twenty-four (24) hours of the Mandated Reporter identifying/suspecting the Physical Abuse; and
   b. A written report shall be made to the local Ombudsman, the corresponding licensing agency, and the local law enforcement agency within twenty-four (24) hours of the Mandated Reporter identifying/suspecting the Physical Abuse.
4. If the suspected Physical Abuse is allegedly caused by a resident of the long term care facility who is diagnosed with dementia, and there is no Serious Bodily Injury, the Mandated Reporter shall report to the local Ombudsman or law enforcement agency by telephone, immediately or as soon as practicably possible, and by written report, within twenty-four (24) hours.

B. **Suspected or Alleged Abuse (Other Than Physical Abuse) in a Long Term Care**

Facility

1. **Please note**: this section relates to reporting suspected Abuse (other than Physical Abuse) which occurred in a long-term care facility but **not** a state mental health hospital or a state development center.
2. If the suspected or alleged Abuse is other than Physical Abuse, a telephone report and a written report shall be made to the local Ombudsman or the local law enforcement agency immediately or as soon as practicably possible. The written report shall be submitted within two (2) working days.

C. **Suspected or Alleged Abuse in a State Mental Hospital or a State Development Center**

1. If the suspected or alleged Abuse resulted in any of the following incidents, a report shall be made immediately, no later than two (2) hours, by the Mandated Reporter identifying/suspecting Abuse to designated investigators of the State Department of State Hospitals or the State Department of Developmental Services, and the local law enforcement agency:
   a. A death.
   b. A sexual assault, as defined in WIC § 15610.63.
   c. An assault with a deadly weapon[3] by a nonresident of the state mental hospital or state development center.
   d. An assault with force likely to produce great bodily injury.[4]
   e. An injury to the genitals when the cause of the injury is undetermined.
   f. A broken bone when the cause of the break is undetermined.
2. All other reports of suspected or alleged Abuse shall also be made within two (2) hours of the Mandated Reporter identifying/suspecting Abuse, to designated investigators of the State Department of State Hospitals or the State Department of Developmental Services, or to the local law enforcement agency.
3. Reports can be made by telephone or through a confidential Internet reporting tool; if reported by telephone, a written report shall be sent, or an Internet report, within two (2) working days.

D. **Abuse Outside of a Long Term Care Facility, State Mental Hospital, or a State Development Center**

1. If the Abuse has occurred in any place other than a long-term care facility, a state mental hospital, or state development center, the report shall be made to the adult protective services agency or the local law enforcement agency.

[3] Penal Code § 245.
[4] Penal Code § 245.

2. Reports can be made by telephone or through a confidential Internet reporting tool; if reported by telephone, a written report shall be sent, or an Internet report, within two (2) working days.

E. **Suspected Abuse when a patient transfers to a receiving hospital**

1. If the Admitting Physician or other persons affiliated with a hospital receives a patient, transferred from another health care facility or community health facility, who exhibits a physical injury or condition that appears to be due to the result of abuse or neglect, they must submit a telephonic and written report within thirty-six (36) hours to both the police and the local county health department. (See Penal Code § 11161.8)

F. **Information to include in Abuse Reports**

1. The report shall include the following, if known:

   a. Name, title, and daytime number of reporting party, agency name and address, and date of report.

   b. Name, address, age and present location of the Elder/Dependent Adult.

   c. Any information that led the reporting party to suspect that Abuse has occurred.

   d. Nature and extent of the Elder/Dependent Adult's condition.

   e. The date and time of incident.

   f. Names and addresses of family members or any other person responsible for the Elder/Dependent Adult's care.

   g. Any other information requested by the adult protective agency.

Riverside	**San Bernardino**
Dependent Adult and Elder Abuse: Adult Services Division (800) 491-7123 (24 hours)	Dependent Adult and Elder Abuse: Department of Aging and Adult Services (877) 565-2020 (24 hours)

Other Related Responsibilities

A. IEHP and its Delegated IPAs are responsible for educating their contracted PCPs and Specialists of the procedures for reporting Abuse cases.

B. IEHP and its Delegated IPAs are responsible for case managing Abuse cases and verifying that reporting has occurred.

C. IEHP and its Delegated IPAs are responsible for documenting Abuse cases on the monthly Case Management Log (See Attachment, "Monthly Care Management Log" in Section 25).

Penalties for Noncompliance

A. Failure to report, or impeding or inhibiting a report of Abuse is a misdemeanor, punishable by not more than six (6) months in the county jail, by a fine of not more than one thousand dollars ($1,000), or both.

B. Any Mandated Reporter who willfully fails to report, or impedes or inhibits a report of Abuse, if that Abuse results in death or great bodily injury, shall be punished by not more than one (1) year in a county jail, by a fine of not more than five thousand dollars ($5,000) or both.

C. If a Mandated Reporter intentionally conceals his/her failure to report an incident known by the Mandated Reporter to be Abuse, the failure to report is a continuing offense until discovered by the applicable law enforcement agency.

REFERENCES:

A. California Welfare and Institutions Code § 15630.

B. California Welfare and Institutions Code § 15610 *et seq*.

C. California Evidence Code § 1010.

D. California Penal Code § 245.

E. California Penal Code § 11161 et seq.

F. California Penal Code § 368 et seq.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	April 1, 2012
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2020

9. ACCESS STANDARDS

E. Access to Services with Special Arrangements

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP and its IPAs ensure that Members have access to medically necessary covered services, including but not limited to services with special arrangements.[1]

PURPOSE:

A. To ensure that Members have access to services with special arrangements.

PROCEDURES:

A. Services with special arrangements include the following:[2]

1. **Family Planning** – Members may access family planning services through any contracted or non-contracted family planning Provider without prior authorization.[3] Please see Policy 10G, "Family Planning Services."
2. **Sexually Transmitted Infection (STI) Preventive Care, Diagnosis and Treatment** – Members may access STI services without prior authorization both within IEHP's Provider network and out-of-network Local Health Department (LHD), any qualified family planning Provider, or any other Provider who treats STI within his or her scope of practice.[4] Please see Policy 10H, "Sexually Transmitted Infection Services."
3. **HIV Testing and Counseling** – Members may access confidential HIV testing and counseling services without prior authorization within IEHP's Provider network and out-of-network LHD or any qualified family planning Provider.[5,6] Please see Policy 10I, "HIV Testing and Counseling."
4. **Immunization –** Immunizations are preventive services not subject to prior authorization requirements.[7,8,9] Please see Policy 10B, "Adult Preventive Services."

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[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 9, Access to Services with Special Arrangements.
[2] Ibid.
[3] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures.
[4] Ibid.
[5] Ibid.
[6] Knox-Keene Health Care Service Plan Act of 1975, § 1367.46.
[7] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures.
[8] DHCS All Plan Letter (APL) 18-004 Supersedes Policy Letter (PL) 96-013 and APL 07-015, "Immunization Requirements".
[9] DHCS APL 16-009, "Adult Immunizations as a Pharmacy Benefit".

5. **American Indian Health Services Programs –** American Indian Members may access contracted and non-contracted American Indian Health Service Programs.

B. Minor Consent Services

1. Members under the age of 18 may access the following services through any Provider within IEHP's Provider network without parental consent:[10]
   a. Treatment for sexual assault, including rape;[11]
   b. Treatment for intimate partner violence;[12]
   c. Drug or alcohol treatment services (for children 12 years of age and older);[13]
   d. Pregnancy-related services;[14]
   e. Family planning services;[15]
   f. STI preventive care, diagnosis, and/or treatment (for children 12 years of age and older);[16]
   g. HIV testing;
   h. Behavioral health care (outpatient mental health care for children 12 years of age and older);[17] and
   i. Abortion services.[18]
2. There are additional regulations that deal specifically with services provided to minors (See Attachment, "California Minor Consent and Confidentiality Law" in Section 9). Prior to any reliance on the information included, please check the citations for a comprehensive understanding of the statutes, as well as any updates and/or changes to the law. Additionally, please refer to your legal counsel for official interpretation or other laws/regulations that may be applicable.

C. Other authorization or access requirements include:

1. **Pregnancy-Related Services –** Services do not require prior authorization and can be provided by any credentialed obstetrical Practitioner (OB/GYN or Family Practice) within the IPA's network.[19]

[10] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Access to Sensitive Services with Special Arrangements.
[11] California Family Code (Fam. Code) §§ 6927 & 6928.
[12] CA Fam. Code § 6930.
[13] CA Fam. Code § 6929.
[14] CA Fam. Code § 6925.
[15] Ibid.
[16] CA Fam. Code § 6926.
[17] CA Fam. Code § 6924.
[18] CA Fam. Code § 6925.
[19] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures.

2. **Abortion Services –** Services do not require prior authorization and can be obtained through any contracted or non-contracted qualified Provider.[20] However, no physician or other health care provider who objects to performing abortion services is required to do so, and no person refusing to perform an abortion is to be subject to retaliation in any form for such a choice.[21]
3. **Behavioral Health Care** - The PCP is responsible for behavioral health care within his/her scope of practice, otherwise, the Member may be referred to the appropriate County Behavioral Health Department. Please see Policy 12K1, "Behavioral Health – Behavioral Health Services" for more information.
4. **Substance Use (Drug or Alcohol) Disorder Treatment Services** - Substance use disorder (SUD) services are provided by the SUD program at the Member's county of residence or Medi-Cal Fee-For-Service (FFS). See Policy 12K2, "Behavioral Health – Substance Use Disorder Treatment Services" for more information.

D. For more specific information regarding authorization requirements and other details, see Sections 10, "Medical Care Standards" and 14, "Utilization Management."

E. Members are informed of their rights to access sensitive services and services with special arrangements through the Member Handbook.[22]

F. Members, regardless of age, may obtain information regarding access to care and assistance with scheduling appointments for sensitive services through IEHP Member Services at (800) 440-4347 or their PCP's office. Assistance is provided with complete confidentiality.

G. Periodic monitoring of Provider compliance is performed through review of encounter data and medical record review. See Policy 6A, "Facility Site Review and Medical Record Review Survey Requirements and Monitoring," for more information.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2021

[20] DHCS All Plan Letter (APL) 15-020 Supersedes Policy Letter (PL) 99-08, "Abortion Services".
[21] CA Health and Safety Code (Health & Saf. Code) § 123420).
[22] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Access to Sensitive Services with Special Arrangements.

CULTURAL & LINGUISTICS (C&L) TRAINING

The goal of the C&L training is to educate IEHP Providers on how to provide medically necessary and covered services to all Members in a culturally and linguistically appropriate manner regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, disability, or gender identity.

Because health care is a cultural construct based on beliefs about the nature of disease and the human body, cultural issues are central in the delivery of health services.

What is Culture?

Culture refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, values, and institutions that unite a group of people.

- We become assimilated into our culture and the way we reflect our culture is often without conscious thought.
- Cultural factors include, but are not limited to, geography, age, socioeconomic status, religion, gender, education, politics, sexual orientation, gender identity, race, and ethnicity.

Cultural Competence is the capability of effectively dealing with people from different cultures.

- Having a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals to enable them to work effectively in cross-cultural situations.
- An active learning process of becoming more culturally competent and promoting cultural engagement.
- Effectively using a combination of knowledge, attitude, and skills.

How does culture impact the care that is given to patients?

Culture informs on:

- Concepts of health, healing;
- How illness, disease, and their causes are perceived;
- The behaviors of patients who are seeking health care; and
- Attitudes toward health care providers.

Culture impacts every health care encounter

Culture defines health care expectations:

- Who provides treatment;
- What is considered a health problem;
- What type of treatment;
- Where care is sought;
- How symptoms are expressed; and
- How rights and protections are understood.

* Cultural Competency Training for Healthcare Providers: Connecting with your patients. Industry Collaboration Effort (ICE) Cultural and Linguistic Services Main Team Cultural Competency Training Workgroup 2013

Inland Empire Health Plan

Cultural & Linguistics (C&L) Training

Examples of Preferred Questions with Members

Demographics	• Where were you born? • Where was "home" before coming to the U.S.? • How long have you lived in the U.S.? • Do you prefer to communicate in a language other than English? • What is the your age, sex, gender identity, and • sexual orientation?
Ideas	• What do you think keeps you healthy? • What do you think makes you sick? • What do you think is the cause of your illness? • Why do you think the problem started?
Views	• Are there any health care procedures that might not be acceptable? • Do you use any traditional or home health remedies? • What have you used before? • Have you used complimentary healers? Which? • What kind of treatment do you think will work?
Expectations	• What do you hope to achieve from today's visit? • What do you hope to achieve from treatment? • Do you find it easier to talk with a male/female? Someone younger/older?
Religion	• Will religious or spiritual observances affect your ability to follow treatment? How? • Do you avoid any particular foods? • During the year, do you change your diet in celebration of religious and other holidays?
Speech	• What language(s) do you prefer to speak? • Do you need an interpreter? • What language(s) do you prefer to read? • Are you satisfied with how well you read? • Would you prefer printed (including Braille, large print, e-text) or spoken instructions (including audio files)?
Environment	• Do you live alone? How many people live in your house? • Can you access all areas in your house? • Do you have transportation? • Who gives you emotional support? Helps when you're ill? • Do you have the ability to shop/cook for yourself? • What times of day do you eat? What is your largest meal?

Inland Empire Health Plan

Cultural & Linguistics (C&L) Training
Limited English Proficiency

Who is a Member with LEP?
Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English, may be considered limited English proficient (LEP)[2].

- Between 1990 and 2010, the U.S. Limited English Proficiency (LEP) increased by 80%[1].
- 19.8% of California's overall population is LEP[1].

Perils of Having LEP[2]

- Receive lower quality health care
- Poorer compliance with medical recommendations.
- Higher risk of medical errors.
- Difficulties understanding their diagnosis or why they receive particular types of care.
- Disproportionately high rates of infectious disease and infant mortality.
- Discordant communication resulting in both lower patient and clinician satisfaction.

How to Identify a Member with LEP over the Phone[3]

- Member is quiet or does not respond to questions.
- Member simply says yes, no, or gives inappropriate or inconsistent answers to your questions.
- Member may have trouble communicating in English or you may have a very difficult time understanding what they are trying to communicate.
- Member identifies as having LEP by requesting language assistance.

[1] U.S. Department of Health and Human Services OPHS, Office of Minority Health National Standards for Culturally and Linguistically Appropriate Services in Health Care
[2] Module 2: Cultural Competency: Race, Ethnicity, Language, and Unconscious Bias in Health Care, Cheri Wilson, MA, MHS, CPHQ
[3] Industry Collaboration Effort Cultural and Linguistics Provider Tool Kit

Inland Empire Health Plan

Cultural & Linguistics (C&L) Training
IEHP Interpreter Services

IEHP offers you FREE INTERPRETER SERVICES during medical appointments with our Members

If you don't have medical staff who speak the same language as our Members, call

IEHP Member Services at
(800) 440-IEHP (4347) or
TTY Users at (800) 718-IEHP (4347)

Interpreter services

Telephone Interpretation – Call IEHP Member Services and you will be connected with an interpreter over the telephone.

Face-to-Face Interpreter – Call IEHP Member Services at least five (5) working days before the scheduled appointment to make arrangements for a foreign language or sign language interpreter. To cancel your request, call at least two (2) working days before the scheduled appointment.

- Members are NOT required or encouraged to use family members or friends as interpreters during medical appointments, unless specifically requested.
- Minors should NOT be used as interpreters (unless it is a medical emergency and no one is available to interpret).
- For telephone interpretation services, twenty-four (24) hours a day, seven (7) days call:

IEHP 24-Hour Nurse Advice Line (888) 244-IEHP (4347)

Remember…

- If you indicate in the IEHP Provider Directory that your office has Spanish-speaking capability, staff that speaks Spanish must be available during your office's regular business hours.
- You must document when a Member requests an interpreter or refuses an interpreter in the Member's medical record.
- An IEHP Provider must not restrict a Member's access to services based on race, color, creed, ancestry, age, gender, national origin, marital status, sexual orientation, gender identity, or physical or mental disability.

Inland Empire Health Plan

Cultural & Linguistics (C&L) Training

Effective Communication and Cultural Understanding to Enhance the Provider-Patient Relationship

How Members and Provider can Access IEHP Interpreter Services

Over the Telephone Interpreters
Available twenty-four (24) hours a day, seven (7) days a week
Call IEHP Member Services at (800)440-4347 or
TTY Users at (800) 718-4347 or
Twenty-four (24) Hour Nurse Advice Line at (888)244-4347

Face-to-Face Interpreters
Including American Sign Language
Call IEHP Member Services at (800)440-4347
at least five (5) working days before the medical visit

IEHP Interpreter Services Policy

- IEHP LEP Members have the right to request an interpreter for medical visit at no cost.
- IEHP and Providers must not require, or suggest to LEP Members that they must provide their own interpreter.
- Friends and family member should not be used unless specifically requested by the Member. **Minors** should not be used as an interpreter.
- Providers must document the **request** or **refusal** of interpreter services in the patient's medical record
- LEP Members have the right to file a grievance or complaint if their language needs are not met.
- Give written instructions whenever possible

Tips for Interviewing Seniors

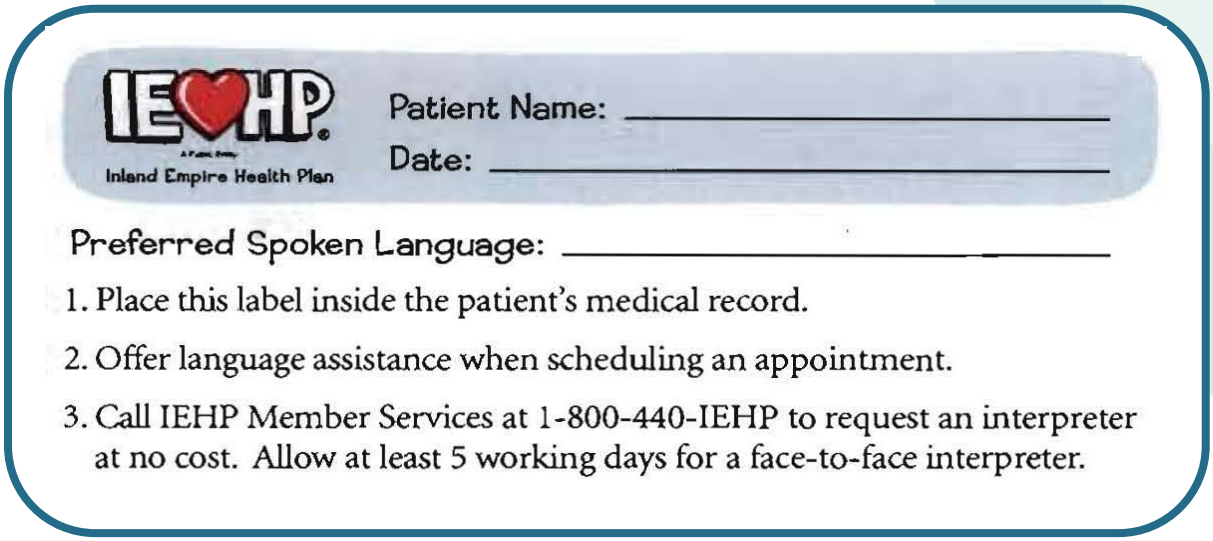
- Mail new patient forms to the patient to complete before the visit.
- Ask if the patient has someone in the lobby waiting and if he/she wants that person in the exam room with him/her.
- Use plain language; avoid medical jargon.
- Use diagrams and/or pictures.
- Demonstrate use of medical equipment.
- Ask patient to repeat back what was said (i.e., how he/she will take medicine, follow care plan or specific treatment, how to use piece of equipment, when to have follow-up visit, etc.)
- Give written instructions whenever possible

Cultural & Linguistics (C&L) Training
IEHP Preferred Language Label

CA Health & Safety Code 123147 requires that, "All health facilities and primary care clinics shall include the patient's principal spoken language on the patient's health records."

To help our providers comply with this requirement, IEHP has created a "**Preferred Language Label**" template for your use (use label #5163 for this label):

- Write down the preferred spoken language of your patient who has Limited English Proficiency (LEP) on the label provided and place it in your patient's medical record. This will let you know if your patient needs language assistance for future appointments.
- If your patient with LEP is already present in the office, call IEHP Member Services at **(800) 440-IEHP (4347) or (800) 718-IEHP (4347) for TTY users.** You will be connected to an interpreter over the telephone.
- Offer your patients with LEP language assistance when scheduling an appointment. Call IEHP Member Services at **(800) 440-IEHP (4347)** at least five (5) working days before the appointment to request a face-to-face interpreter. To cancel the request, call at least two (2) days before your doctor visit.
- All interpreter services are available to IEHP Members at NO COST.



Inland Empire Health Plan

Cultural & Linguistics (C&L) Training
Access for Seniors & Persons with Disabilities
Accessibility Training

How to Make your Medical Office Accessible

Persons with disabilities face many secondary health problems, yet they are less likely to get routine medical care than people without disabilities. You can help change that.

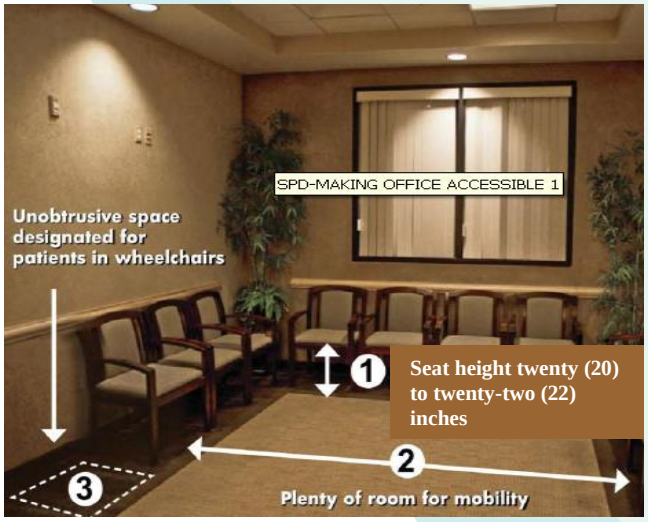
By making your facilities accessible you convey a sense of welcome for people with disabilities. Most of all, you comply with the requirements set by the Americans with Disabilities Act of 1990 (ADA). This is a civil rights law that prohibits discrimination against persons with disabilities on the basis of their disability in programs and services that receive federal financial assistance.

The Waiting Room

Why it matters: The right seating layout can prevent a person who uses a wheelchair from feeling out of place.

Accessible tips:

1. Seat height should be twenty (20) to twenty-two (22) inches, allowing a patient to get up from a chair with no strain.
2. Thirty-six (36) inches minimum is provided for circulation behind a group of chairs, allowing a wheelchair to move about; thirty-two (32) inches in front of the chairs for ambulatory movement.
3. **What you can do:** Remove a few chairs. This allows a wheelchair to fit, putting the user at ease.



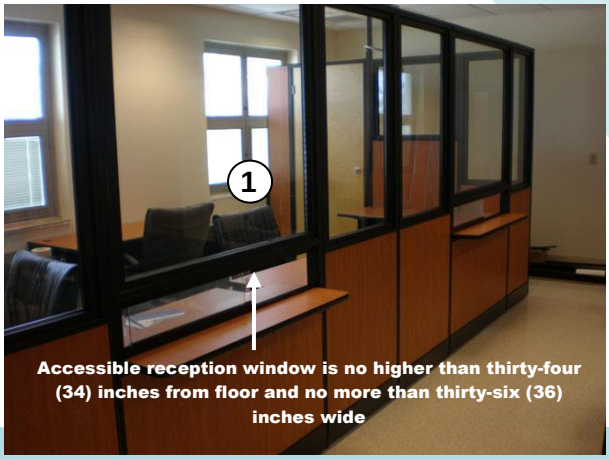
Reception Counter Window

Why it matters: If a counter is too high, a person who uses a wheelchair may have trouble using it to fill out forms or have face-to-face interaction.

Accessible tips:

1. Counter height should be no height than thirty-four (34) inches from the ground and thirty-six (36) inches wide.

What you can do: Provide a clipboard, allowing a person who uses a wheelchair to fill out forms.



Circulation Paths

Why it matters: People who are blind or have low vision may stumble over objects in the way. If they are unable to detect an object by using the sweep of their cane, they could get hurt

Accessible tips:

1. Accessible routes should connect to other public and common use spaces.
2. Clear walkways, halls, corridors or aisles of objects protruding into circulation paths from side or from posts

What you can do: Remove objects that obstruct paths. Move large objects like planters or coffee table out of the way.

Exam Room

Why it matters: Most exam rooms are too small for a person using a wheelchair or for someone with a mobility disability

Accessible tips:

1. To make your exam room accessible, start with an accessible path to and through the room. This allows patients to enter and move about.

What you can do: Provide at least one (1) exam room with accessible features; more such rooms are needed in a large clinic.

Turning Space Inside Exam Room

Why it matters: A person using a wheelchair needs enough space to approach the exam table and any other equipment

Accessible tips:

1. Thirty (30) by fourty-eight (48) inches is the minimum amount required, allowing a person using a wheelchair to approch the side and transfer to table.

What you can do: Clear up floor space along both sides of an adjustable height exam table.

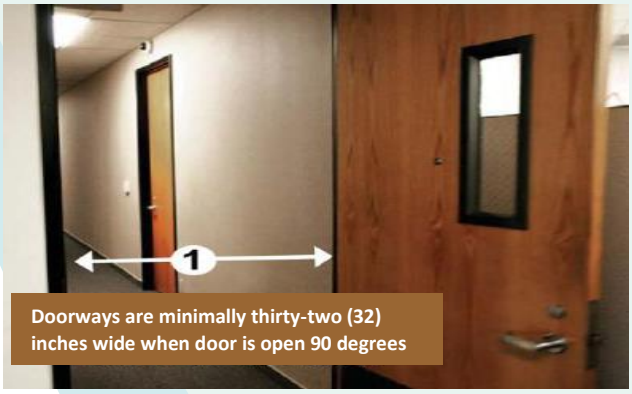
Doorways

Why it matters: Some doorways are too narrow for a wheelchair to pass through.

Accessible tips:

1. A door should offer enough clear width, maneuvering clearance and accessible hardware. An accessible doorway must have a minimum clear opening of thirty-two (32) inches when the door is opened nonety (90) degrees.

What you can do: Check the hallway outside the door and the space inside the door. Keep it free of objects that could interfere with the maneuvering clearance or accessible route.



Door Knobs

Why it matters: For some person with a mobility disability, a door knob is hard to open because it requires tight grasping, pinching and twisting.

Accessible tips:

1. Mounting hardware for accessible door passage should be no higher than fouthy-eight (48) inches from the floor.

What you can do: Install door handles with an easy-to-grasp shape which can be used with one (1) hand without tight grasping, pinching or twisting. Here are some good options: 2) Lever Handle, 3) Push Bar.

Open Space by Exam Table

Why it matters: Some persons can only transfer from the right or left side of exam table.

Accessible tips:

1) and 2) provide clear floor space on both side of exam table.

What you can do: If you have more than one (1) exam room, reverse the furniture layout. Move Aside objects like chair or waste baskets.

Open Space by Exam Table

Why it matters: For most people with a mobility disability a traditional fixed height exam table is too high.

Accessible tips:

1. So patients can transfer from their wheelchair, use a height adjustable exam table
2. It should have a support rail along one (1) side and lower to height of a wheelchair seat, seventeen (17) to nineteen (19) inches (or lower) from floor. Plus, it should have elements like rails, straps or cushions to stabilize and support a person during transfer and while on the table.

What you can do: Use pillows, rolled up towels or foam wedges to stabilize and position the patient on
the table.

Provider Training Etiquette
Interacting with People with Disabilities

General Tip

- Focus on the person, not on the disability
- Offer people with a disability the same dignity, consideration, respect, and rights you expect for yourself.
- Do not be afraid to make a mistake. Relax.
- Do not patronize people by patting them on the head or shoulder.
- Address people with disabilities by their first names only when extending the same familiarity to all others present.
- Do not assume that a person with disability needs assistance. Ask before acting. If you offer assistance, wait until the offer is accepted. Then wait for or ask for instructions. Respect the person's right to indicate the kind of help needed. Do not be offended if your help is not accepted. Many people do not need help. Insisting on helping a person is the same as taking control away from them.
- If the person with a disability is accompanied by a friend or family member, look at and speak direct to the person with disability rather than to or through the other person.
- If service counters are too high for some user, such as people of short stature and people using wheelchairs, step around counters to provide service. Keep a clipboard or other portable writing surface handy for people unable to reach the counter when signing documents.

- Know the location of accessible routes including parking spaces, restrooms, drinking fountains, dressing rooms, and telephones.

Watch for and remove these common barriers

- Vehicles blocking ramps
- Housekeeping and cleaning carts blocking hallways and restrooms
- Potted plants, benches, trash cans and other items blocking access to ramps, railings and elevator call buttons
- Parking personnel using an accessible parking space as waiting areas

Language Issues

- Avoid referring to people by their disability i.e., “an epileptic.” A person is not a condition. Rather, they are “people with epilepsy” or “people with disabilities.”
- People are not “bound” or “confined” to wheelchairs. Wheelchairs are used to increase mobility and enhance freedom. It is more accurate to say, “wheelchair user” or “person who uses a wheelchair.

Other words to avoid because they are negative, reinforce stereotypes and evoke pity include:

- Abnormal
- Maimed
- Burden
- Misshapen
- Disfigured
- Spaz
- Invalid
- Unfortunate
- Lame

People with Hearing Disabilities

- Ask people how they prefer to communicate.
- To get the attention of a person, lightly touch the individual or wave your hand. Look directly at the person and speak clearly, slowly and expressively to establish if the person can read your lips. Not all people can lip-read. For those who do, be sensitive to their needs by positioning yourself facing them and the light source. Keep your hands and food away from your mouth when speaking. Avoid chewing gum and smoking while speaking.
- Use a normal tone of voice unless you are asked to raise your voice. Shouting or exaggerating your words will not help.
- Slow your speaking rate if you tend to be rapid speaker.
- Make sure you have good light on your face.
- Do not run your words together.
- Avoid complex and long sentences.
- Pause between sentences to make sure you are understood.
- If you are giving specific information such as time, place, address or phone numbers, it is good practice to have it repeated back to you.
- If you cannot understand what is said, ask people to repeat it or write it down. Do not act as if you understand unless you do.

- If the person cannot lip read, try writing notes. Never assume that writing notes will be an effective way to communicate with all people who are deaf. Some may not be strong in written English, since ASL (American Sign Language) is their primary language, which is very different from English as a language.
- If a person who is deaf is using an interpreter, always speak directly to the person, not the interpreter.
- If you cannot make yourself understood try writing notes or drawing pictures.

People with Speech Disabilities

- Do not raise your voice. People with speech disabilities can hear you.
- Give individuals your full attention and take time to listen carefully.
- Always repeat what the person tells you to confirm that you understood.
- Ask questions one (1) at a time.
- Give individuals extra time to respond.
- Pay attention to pointing, gestures, nods, sounds, eye gaze and eye blinks.
- Do not interrupt or finish individuals' sentences. If you have trouble understanding a person's speech do not be afraid to ask them to repeat what they are saying, even three or four times. It is better for them to know that you do not understand than to make an error.
- If you still cannot communicate, try using paper and pen or ask them to spell the message. Do not guess.
- Ask them to:

"Show me how you say YES"	Yes – one (1) blink
"Show me how you say NO"	No – two (2) blinks
"Show me how you point"	Help – three (3) blinks

- Teach people to indicate these phrases:
  "I don't know"
  "Please repeat"
  "I don't understand"
- For phone calls try using the Speech-to-Speech Relay Service by calling 711, a form of Relay Services that provide Communications Assistants (CAs) for people with speech disabilities. This includes those who use speech generating devices and who have difficulty being understood on the phone. CAs have strong language recognition skills and are trained individuals familiar with many different speech patterns. The CA makes the call and repeats the words exactly.
- Give people time to answer you and consider using open-ended questions.

People with Vision Disabilities

- When offering help, identify yourself and let people know you are speaking to them by gently touching their arm. If you leave people's immediate area, tell them, so they will not be talking to an empty space.
- Speak directly facing the person. Your voice will orient the person. Your natural speaking tone is sufficient.
- When giving directions, be specific and describe obstacles in the path of travel. Clock clues may be helpful, such as "the desk is at 6 o'clock." Avoid pointing or using vague terms like "that way."
- Directions should be given for the way they are facing. For example, "the restroom stall is about 7 steps in front of you."
- When serving as a guide, ask, "Would you like to take my left (or right) arm?" The movements of your arm will let them know what to expect. Never grab or pull people.
- When leading a person through a narrow space such as an aisle, put your arm they are holding on to behind your back as a signal that they should walk directly behind you. Give verbal instructions as well, such as "we will be walking through a narrow row of chairs."
- When guiding a person through a doorway, let them know if the door opens in or out and to the right or to the left.
- Before going up or down steps, come to a complete stop. Tell people the direction of the stairs (up or down) and the approximate number of steps. If a handrail is available, tell them where it is.
- When showing a person to a chair, place your hand on the back of the chair. They usually will not need any more help in being seated.
- If a person is using a service animal, the animal's attention should not be sidetracked. It is important not to pet or speak to the animal.
- When offering information in alternative formats (Braille, large print, disks, audio) ask people what format works best for them.
- When to help in signing a document, ask if they want you to show them the location of the signature line.

Quick Tips to Avoid HIPAA Privacy Breaches

- Avoid discussing patient information with office staff where others can hear.
- Never use the speakerphone to check voicemails near the waiting room.
- Do not use patient sign-in sheets that displays social security numbers, birth dates or reason for visit.
- File a patient's chart right away after each visit to avoid other patients seeing them.
- Do not ask people with disabilities sensitive questions in the waiting room.

Inland Empire Health Plan

Cultural & Linguistics (C&L) Training

Examples of Preferred Terms Regarding People with Disabilities

Acceptable – Neutral (Always subject to change and continuing debate)	Unacceptable – Offensive
He had polio. She has multiple sclerosis.	He was **afflicted** with, **stricken** with, **suffers from**, **victim** of polio, multiple sclerosis, etc.
He has arthritis. She has cerebral palsy.	He is **arthritic**. She is **cerebral palsied, spastic**.
A person who has had a disability since birth… A congenital disability	**Birth defect**
A person who uses a wheelchair. A wheelchair user.	Confined to a **wheelchair/wheelchair bound**
She has a disability.	She is **crippled**
A person who has a speech disability. A person who is hard of hearing. A person who is deaf.	**Dumb, deaf mute, dummy** (implies an intellectual disability occurs with a hearing loss or a speech disability).
A person who has a spinal curvature.	A **hunchback** or a **humpback**.
He has a mental illness. He has an emotional disability. He has a psychiatric disability.	He is **chronically mentally ill, a nut, crazy, idiot, imbecile, moron.**
People of short stature.	**Midgets, dwarfs.**
A person who has a speech disability.	**Mute**
A person without a disability as compared to a person with a disability.	**Normal person, whole person, healthy person, able-bodied person** as compared to a disabled person.
She lives with a disability.	**Overcame** her disability
A person who has a developmental disability or intellectual disability.	**Retard, retardate, mentally retarded, feebleminded, idiot…**
Use only when a person is actually ill.	**Sick**
Use only when a person is actively being seen or treated by a health care provider	Stroke **patient,** multiple sclerosis **patient**
Seizure	**Fit**
Older people with disabilities	**Frail**
Person with environmental sensitivities	**Bubble Person**

Inland Empire Health Plan

Cultural & Linguistics (C&L) Training

Accessibility Checksheet

How can your doctor's office serve you better? During a healthcare visit, do you need extra help? After your visit, maybe you need help to contact your doctor's office, to set up a new appointment, or to use your health benefits. Tell your doctor what your needs are by filling out this checksheet.

Name: _____ Date of Birth: _____ Today's Date:_____

E-mail: _____Cell Phone: _____ Home Phone: _____

How does your disability impact your healthcare visits? Tell us. Examples:

1. I use a wheelchair and need assistance to transfer to an exam table.
2. I have low vision and prefer large print text.
3. I am hard-of-hearing and need written communications.
4. My developmental disability requires more time for office visits.

Write in area below:

_____

_____

Communications

See the choices below. To make (or confirm) appointments or to trade information during your next office visit, which method would you prefer? You can check more than one.

☐ California Relay Services ☐ E-mail ☐ Other _____

☐ Sign Language Interpreters ☐ Text message

For information mostly given in print form, you prefer …

☐ Large print ☐ Braille ☐ Audio tape or Audio CD

☐ E-mail ☐ Electronic format CD ☐ Other _____

Exam room

What type of medical equipment do you need?

☐ Height adjustable exam table ☐ Wheelchair accessible weight scale

☐ Height adjustable mammography ☐ Other _____

Do you need to be lifted on the medical equipment?

☐ Yes ☐ No

Do you use a mobility device that requires more space in the exam room?

☐ Yes ☐ No

Extra Time

When you call for an appointment time, do you need more choices?

☐ Yes ☐ No

Transportation

How do you get to and from your doctor visits?

☐ Self (private car or van) ☐ Public transit (bus) ☐ Other _____

☐ Driver or caregiver (private car or van) Driver's phone # _____
Paratransit, Paratransit's phone # _____

Other help

What other forms of help do you need?

☐ Assistance filling out paperwork ☐ Service Animal ☐ Other _____

Cultural & Linguistics (C&L) Training

Independent Living and Diversity Services (ILDS) is a collaboration of Outreach and Administrative staff who provide services to IEHP Members with Disabilities and Providers. ILDS mission is to improve access, communication, and health care services for seniors and persons with disabilities. Independent Living and Diversity Services also engages in outreach activities to develop and maintain meaningful relationships with community based organizations that provides Members with access to social community-based supports that promote health, education, and independence.

IEHP Resource Referral Service

For seniors and people with disabilities

Inland Empire Health Plan

What is the Disability Resource Referral Service?

This is a new service offered by the IEHP Disability Program that connects seniors and people with disabilities to resources in the community.

Types of Resources:

- **Independent Living Centers** – These provide peer support, independent living skills training and more for people with disabilities.
- **Transportation** – Many organizations in Riverside and San Bernardino County can help with transportation to Doctor visits, grocery shopping, and other activities at little to no cost.
- **Assistive Technology** – This helps people with disabilities live, work, learn and play as independently as possible. The IEHP Disability Program connects Members to organizations that provide Assistive Technology at no cost to them.
- **Support Groups** – The IEHP Disability Program can refer Members to a variety of support groups that meet specific needs.
- **Basic Needs** – People with disabilities can get referrals to food banks, utility help, and other basic resources available in their community.
- **Education** – Advocacy programs aim to make sure students with disabilities are engaged and provided with a free public education.
- **Employment** – Members with disabilities can get access to job services, resume writing and other programs.
- **Housing** – Members can get referrals to agencies that can help with finding housing and other resources.

To learn more, call IEHP Member Services at: **1-800-440-IEHP** (4347) or 1-800-718-4347 TTY, Monday – Friday, 8am – 5pm (PST), or visit **iehp.org**.

Community Resources		
Behavioral Health	**Phone**	**Counties**
Dept. of Behavioral Health	(888) 743-1478	SB
	(800) 706-7500	RIV
African American Health Coalition	(909) 880-1343	SB
Asian American Resource Center	(909) 383-0164	SB/RIV
Indian Health, Inc	(909) 864-1097	SB/RIV
Blind / Low Vision	**Phone**	**Counties**
Blindness Support Service	(951) 341-9244	SB/RIV
Lighthouse for the Blind	(909) 884-3121	SB/RIV
Braille Institute	(760) 321-1111	SB/RIV
Deaf / Hard-of-Hearing	**Phone**	**Counties**
Center on Deafness	(951) 275-5000	SB/RIV
CA School for the Deaf	(951) 824-8114	SB/RIV
Disability Resource Centers	**Phone**	**Counties**
Rolling Start	(909) 890-9516/ (760) 949-7626	SB
Community Access Center	(951) 274-0358	RIV
Inland Regional Center*	(909) 890-3148	SB
*Serves Developmental Disabilities	(951) 826-2648	RIV
Domestic Violence	**Phone**	**Counties**
National Domestic Violence Hotline	(800) 799-7233	SB/RIV
Adult Protective Services	(877) 565-2020	SB
	(800) 491-7123	RIV
Option House, Inc	(909) 383-1602	SB
Coalition for Alternatives to Domestic Violence	(951) 320-1370	RIV

Community Resources (Continued)		
Employment	**Phone**	**Counties**
Dept. of Rehabilitation	(951) 782-6650	SB/RIV
Goodwill Industries	(909) 885-3831	SB
	(951) 955-3101	RIV
Career Institute	(909) 388-6003	SB
Food Assistance	**Phone**	**Counties**
Mobile Fresh	(951) 686-1096	SB/RIV
Helping Hands Pantry	(909) 796-4222	SB
Feeding America	(951) 359-4757	RIV
Cal-Fresh	(877) 410-8827/ (877)410-8829	SB/RIV
Higher Education	**Phone**	**Counties**
CSU San Bernardino	(909) 537- 5000	SB
SB Valley College	(909) 384-4400	SB
UC Riverside	(951) 827-1012	RIV
Riverside Community College	951-222-8000	RIV
In Home Services / Meals	**Phone**	**Counties**
In Home Support Service	(877) 800-4544	SB
	(888) 960-4477	RIV
Family Services Association	(951) 342-3057	SB/RIV
Home Delivered Meals	(800) 510-2020	SB/RIV
Meals at Senior Centers	(800) 510-2020	SB/RIV
Legal	**Phone**	**Counties**
Disability Rights Legal Center	(213) 736-1334	SB/RIV
Disability Rights California	(213) 213-8000	SB/RIV
Inland Legal Services	(909) 884-8615	SB

Community Resources (Continued)		
	(951) 368-2555	RIV
Riverside Legal Aid	(951) 682-7968/ (760) 347-9456	RIV
Inland Fair Housing	(800) 321-0911	SB/RIV
LGBT+	**Phone**	**Counties**
LGBTQ Center San Bernardino	(909) 907-4249	SB
TruEvolution	(951) 888-1346	SB/RIV
Transgender Community Coalition	(833) 944-5433	RIV
Desert AIDS Project	(760) 323-2118	RIV
Foothill AIDS Project	(909) 884-2722	SB
	(951) 742-7660	RIV
Recreation	**Phone**	**Counties**
PossAbilities Program	(909) 558-6384	SB/RIV
Center for Individual Development	(909) 384-5426	SB
Casa Colina Outdoor Adventures	(909) 596-7733/ (866) 724-4127	SB/RIV
Ability First	(909) 621-4727	SB
Seniors	**Phone**	**Counties**
Dept. of Aging and Adult Services	(909) 891-3900	SB
Office on Aging	(951) 867-3800/ (760) 771-0501	RIV
Senior Companions	(909) 384-5413	SB
	(951) 929-9691	RIV
Social Services Programs	**Phone**	**Counties**
Referrals to Social Services Agencies	2-1-1	SB/RIV
Telecommunications	**Phone**	**Counties**
CA Telephone Access Program	(800) 806-1191	SB/RIV
CA Relay Services	7-1-1	SB/RIV

Community Resources (Continued)		
Life Wireless	(888) 543-3620	SB/RIV
SafeLink Wireless	(800) 723-3546	SB/RIV
Transportation	**Phone**	**Counties**
Omnitrans - Access ADA	(909) 379-7100	SB
Riv. Transit Agency: Dial-A-Ride	(800) 795-7887	RIV
All Resources	**Website**	**Counties**
Connect IE	www.connectie.org	SB/RIV

SAMPLE

Make Referrals Easy

Overview
• Primary care practices refer patients to specialists, ancillary health care clinicians, labs and screening facilities, and elsewhere. Making the referral process easy for patients increases the chances that they will follow through, and that both you and the referral destination get all the information you need.
Actions

• **Refer patients to clinicians who coordinate care with you.**
  ○ Identifying, developing, and maintaining relationships with clinicians to whom you refer patients can make the referral process run smoothly.
  ○ **Try to establish formal referral agreements** with key specialist groups and other clinicians.
  ○ Don't continue to refer patients to clinicians who do not send information back to you, don't provide timely appointments for your patients, or otherwise fail to coordinate care.

Referral Agreement

• **Referral agreement spells out mutual expectations and responsibilities, such as:**
  ○ **Which patients are appropriate to refer**
  ○ **What information is needed before and after a referral**
  ○ **Roles for both parties after the referral**
  ○ **Setting aside appointments for urgent care**

Don't rely on patients to relay information.
• **Share important information directly with the other office,** such as the reason for the referral, pertinent medical history, and test results. • **Explore making electronic referrals.** Check whether your EHR has the capability to make referrals directly to other clinicians. If not, self-standing referral management systems are commercially available for purchase. • Provide a detailed referral to the other clinician that contains all the information needed. The Improving Chronic Illness Site has a guide on Reducing Care Fragmentation, which includes a checklist of information to provide to specialists for each referral. • **Get information sent directly back to you.** Make sure you get a full report back before your patient's next visit.
Consider language barriers.
• When making referrals for patients with limited English proficiency, **identify clinicians who are language concordant or have interpreter services.** Address Language Differences for more information on language assistance. • **Include information on your patient's language assistance needs** when making the referral.
Make sure the patient understands the reason for the referral.
• **Explain why** the patient needs to be seen by someone else, and what might happen if he or she is not seen. • In the case of tests, **explain how you and the patient will use the information** to diagnose, manage, or decide on treatments for health conditions. • In the case of screenings, **give a clear explanation of the risks and benefits.** Ultimately, it's up to the patient as to whether or not to undergo any particular test or screening. • **Use the teach-back method.** Use the Teach-Back Method) to confirm patient understanding. • **Ask about and address any concerns or fears.**

Offer help with the referral.

- Ask patients if they would like your office to make the initial phone call.
- If staff members are making appointments for patients, make sure they first find out when the patients are available.
- Ask patients about transportation and other barriers to their completing the referral. Discuss how they could overcome these barriers. Use Tool 18: Link Patients to Non-medical Support to refer them to other services that could support their completion of the referral.

Provide clear instructions.

- For some referrals, patients will need to prepare in advance (e.g., fast, discontinue a medicine). Provide easy-to-understand instructions verbally and in writing.
- Explain the referral process fully (e.g., how you and the other clinician will exchange information, when the patient should return to your office).
- Give clear oral and written directions to get to the referral location.
- Use the teach-back method to confirm patient understanding.

Follow up on referrals.

- Confirm and document that the patient successfully completed the referral.
- Obtain information on the result of the referral and document in the medical record.
- Make sure the patient receives the results of any tests or screenings, even normal results.
- Provide patients positive feedback for completing referrals. Let patients see how you use the information obtained from tests or specialist visits.
- If the patient has not completed the referral, reinforce that you feel the patient could benefit, and review barriers.
- Determine whether the patient needs additional referrals.
- Get feedback from patients on the quality of the care provided. Stop making referrals to places that consistently receive negative reports.

Track Your Progress

- Select a sample of referrals made during a week. Examine the referral records to calculate the percentage of referrals that included all relevant information. One month later, calculate the percentage of patients whose referral results are in their medical records.
- Select a sample of patients who were sent for lab tests during a week. One month later, calculate the percentage of patients who have completed the test and the percentage who have been notified of the test results.
- One month after implementing this Tool, ask a sample of patients who have not completed referrals why they did not follow through. Develop and implement an improvement plan to address the reasons they give. Repeat in 2, 6, and 12 months.

Resources

- AHRQ Health Literacy Universal Precautions Toolkit, Second Edition, available at http://www.ahrq.gov/literacy
- Care Coordination: Relationships and Agreements describes a package of changes, activities, and resources for primary care practices seeking to improve coordination.
- Improving Your Office Testing Process: A Toolkit for Rapid-Cycle Patient Safety and Quality Improvement contains tools for referring to patients and following up on tests.

Sample

AFTER HOURS SCRIPT

One of the following scripts may be used by your medical office as a template for ensuring members have access to timely medical care after normal business hours.

CALLS ANSWERED BY A LIVE VOICE (E.G. ANSWERING SERVICE OR CENTRALIZED TRIAGE):

- If the situation is an emergency, advise the caller to call 911 immediately.
- If the member indicates a need to speak with a physician, facilitate the contact with the physician by:
    1. Putting the caller on hold momentarily and then connecting the caller to the on-call physician, or
    2. Get the members number and advise a physician will call them back within the hour, or
    3. Giving the caller the pager number for the on-call physician and advising them to call back if they have not heard from the physician within one hour.
    4. If a member indicates a need for interpreter services, facilitate the contact by accessing interpreter services.

CALLS ANSWERED BY AN ANSWERING MACHINE

If this is an emergency, please hang up and call 911 immediately.

Hello, you have reached (Name of the Doctor/Medical Group). If you wish to speak with the physician on-call,

1. Please hold and you will be connected to (Doctor)_____.
2. You may reach the on-call doctor directly by calling_____.
3. Please call_____. The doctor will be paged and you may expect a return call within one hour. (Please provide patient's instruction in case the provider is unable to return their call within hour).
4. Our Urgent Care Center is located at _____.

[Appropriate language options should be provided for the location.]

IMPORTANT: Effective telephone service after normal business hours' providers for callers to reach a live voice or answering machine.

SAMPLE

On-Call Provider Schedule and Contact Numbers

Dates Effective:_____

DAY	Scheduled MD On-Call	Contact Number	Alternate MD On-Call	Alternate Contact Number
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
After Hours				

9. ACCESS STANDARDS

A. Access Standards

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members and Providers.

POLICY:

A. All applicable Practitioners including Primary Care Providers (PCPs) and Specialists must meet the access standards delineated below to participate in the IEHP network.

B. IPAs are responsible for monitoring their network to ensure adherence with the access standards described in this policy.

C. IEHP monitors plan-wide adherence to these access standards through IEHP and IPA performed access studies, review of grievances and other methods.

D. All Members must receive access to all covered services without regard to sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code Section 422.56, except as needed to provide equal access to Limited English Proficiency (LEP) Members or Members with disabilities, or as medically indicated.[1]

DEFINITIONS:

A. **Emergency Medical Condition** – This is a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

   1. Placing the health of the individual (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
   2. Serious impairment to bodily function; or
   3. Serious dysfunction of any bodily organ or part.

B. **Urgent Care Services** – These are health care services needed to diagnose and/or treat medical conditions that are of enough severity that care is needed urgently but are not emergency medical conditions.

C. **Urgent Visit** – These are visit to health care professionals to address an urgent but non-emergency medical conditions.

D. **Non-Urgent (Routine) Visit** – These are health care services needed to diagnose and/or treat medical conditions that do not need urgent care or emergent attention.

[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 2, Provision 28, Discrimination Prohibitions

E. **Initial Health Assessment** – See Policy 10A, "Initial Health Assessment.

F. **Physical Examination –** This is a routine preventive exam occurring every one to three (1-3) years.

G. **Walk-In Clinic Visits –** If an IEHP Member is informed by the PCP or the PCP's office staff that they may "walk-in" on a particular day for urgent or routine visits, the IEHP Member must be seen at that office on the same day in which the Member was advised to visit.

H. **Urgent Prenatal Visit** – These are health care services needed to diagnose and/or treat actual or perceived prenatal conditions that are of sufficient severity that care is needed urgently but are not emergency medical conditions.

I. **Initial Prenatal Visit** – These are health care services needed to determine potential risk factors and the care plan for a woman during the period of pregnancy.

J. **Non-Urgent (Routine) Prenatal Care** – These are routine medical visits throughout the period of pregnancy. These visits consist of periodic exams and monitoring for the determination of the condition of both the fetus and the mother.

K. **Non-Urgent (Routine) Specialist Visit** – These are referrals to a health care professional who has advanced education and training in a specific area.

L. **Triage or Screening** – This means the assessment of a Member's health concerns and symptoms through communication with a physician, registered nurse (RN), or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who many need care, for the purpose of determining the urgency of the enrollee's need for care. Other qualified health professionals include nurse practitioners (NP) and physician assistants (PA).

PROCEDURES:

A. **Access Standards for Clinical Services**

1. Appointment Availability Standards - Members must be offered appointments within the following timeframes:[2]

Primary Care Providers (PCP) and Obstetrics/Gynecology (OB/GYN) Primary Care	
Type of Appointment	**Timeframe**
Emergency	Immediate disposition of Member to appropriate care setting
Urgent visit for services that do not require prior authorization[3]	Within forty-eight (48) hours of request

[2] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 3, Access Requirements
[3] Knox-Keene Health Care Service Plan Act of 1975, § 1300.67.2.2

9. ACCESS STANDARDS

A. Access Standards

Primary Care Providers (PCP) and Obstetrics/Gynecology (OB/GYN) Primary Care	
Type of Appointment	**Timeframe**
Urgent visit for services that do require prior authorization[4]	Within ninety-six (96) hours of request
Non-urgent (routine) visit[5,6]	Within ten (10) business days of request
Physical examination[7]	Within thirty-six (36) business days of request
Initial health assessment[8,9]	Within one hundred twenty (120) calendar days of enrollment
Initial health assessment (under 18 months of age only)	Within sixty (60) calendar days of enrollment
Well-Woman Examination[10]	Within thirty-six (36) business days of request
Follow up exam	As directed by Physician

Specialist	
Type of Appointment	**Timeframe**
Emergency	Immediate disposition of Member to appropriate care setting
Urgent visit for services that do <u>not</u> require prior authorization[11]	Within forty-eight (48) hours of request
Urgent visit for services that do require prior authorization[12]	Within ninety-six (96) hours of request
Urgent prenatal visit[13]	Within forty-eight (48) hours of request
Non-urgent (routine) visit[14,15]	Within fifteen (15) business days of request
Non-urgent visit for ancillary services (for diagnosis or treatment of injury or other health condition)[16]	Within fifteen (15) business days of request

[4] KKA, § 1300.67.2.2
[5] Ibid.
[6] Department of Health Care Services (DHCS) All Plan Letter (APL) 21-006 Supersedes APL 20-003, "Network Certification Requirements
[7] KKA, § 1300.67.2.2
[8] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 5, Services for Member under Twenty-One (21) Years of Age
[9] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 6, Services for Adults
[10] KKA, § 1300.67.2.2
[11] Ibid.
[12] Ibid.
[13] Ibid.
[14] Ibid.
[15] DHCS APL 21-006
[16] KKA, § 1300.67.2.2

9. ACCESS STANDARDS

A. Access Standards

Specialist	
Type of Appointment	**Timeframe**
Initial Prenatal Visit[17]	Within ten (10) business days of request
Non-urgent (routine) prenatal care[18]	Within ten (10) business days of request
Well-Woman Examination[19]	Within thirty-six (36) business days
Follow up exam	As directed by Physician

a. Shortening or Expanding Appointment Times – The applicable waiting time to obtain a particular appointment may be extended if the referring or treating licensed health care Practitioner, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the Member's medical record that a longer waiting time will not have a detrimental impact on the health of the Member.[20]

b. Preventive Care – Preventive care services and periodic follow-up care may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care Practitioner acting within the scope of his or her practice. Periodic follow-up care includes but is not limited to, standing referrals to Specialists for chronic conditions, periodic office visits to monitor and treat pregnancy and other conditions, laboratory and radiological monitoring for recurrence of disease.[21]

c. Missed Appointments – When it is necessary for a Provider or a Member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the Member's health care needs, and ensures continuity of care consistent with good professional practice, and ensure the Member's timely access to needed health care services.[22] Please see Policy 9B, "Missed Appointments," for more information.

2. Waiting Times[23]

a. Practitioner Office – For primary or specialty care, the waiting time for a scheduled appointment must be no longer than sixty (60) minutes. Waiting times for Members that are advised to "walk-in" to be seen must be no longer than four (4) hours.

b. Urgent Care Center – Urgent Care Centers are designed to serve Members, who are

[17] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 3, Access Requirements
[18] KKA, § 1300.67.2.2
[19] Ibid.
[20] Ibid.
[21] Ibid.
[22] Ibid.
[23] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 3, Access Requirements

unable to make an appointment with their PCP or Specialist for their urgent non-emergent conditions. Urgent Care Centers accept unscheduled walk-in patients; therefore, waiting time in Urgent Care Centers can vary depending on the number of Members waiting to be seen.

c. Health Plan Call Center – During normal business hours, the waiting time for a Member to speak by telephone with a plan representative knowledgeable and competent regarding the Member's questions and concerns shall not exceed ten (10) minutes.[24] Initial answer by an automatic answering system is acceptable if it has an option to directly access a live person. Calls received after normal business hours (Monday-Friday, 8am-5pm) are returned within one (1) business day. Calls received after midnight are responded to the same business day.[25,26]

d. Triage, Screening and Advice – The waiting time to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a Member who may need care, must not exceed thirty (30) minutes.[27]

3. Time or Distance Standards

a. Proximity of PCPs and OB/GYN Primary Care to Members – IEHP network PCPs must be located within ten (10) miles or thirty (30) minutes travel time from the Member's residence, as applicable, based on geographic regions.[28]

b. Proximity of Specialists, OB/GYNs, Behavioral Health, and other Providers – IEHP network Specialists, OB/GYNs, Behavioral Health and other Providers must be located within these distances:[29]

1) For Riverside County, within thirty (30) miles or sixty (60) minutes travel time from the Member's residence; or

2) For San Bernardino County, within forty-five (45) miles or seventy-five (75) minutes travel time from the Member's residence.

c. Proximity of Hospital – IEHP network hospitals must be located within fifteen (15) miles or thirty (30) minutes travel time from their assigned Members' residence, as applicable, based on geographic regions.[30,31]

4. Proximity of Pharmacy – IEHP network pharmacies must be located within ten (10) miles or thirty (30) minutes travel time from the Members' residence, as applicable, based on

[24] KKA, § 1300.67.2.2
[25] National Committee for Quality Assurance (NCQA), 2021 Health Plan Standards and Guidelines, ME 4, Element B
[26] NCQA, 2021 HP Standards and Guidelines, ME 5, Element B
[27] Ibid.
[28] DHCS APL 21-006
[29] Ibid.
[30] KKA, § 1300.51
[31] DHCS APL 21-006

geographic regions.[32]

5. In instances where IEHP does not meet time or distance standards for specific Provider types in IEHP's service region, IEHP will allow Members to see a Provider who is not currently in IEHP's contracted network under the requirements of an Annual Network Certification (ANC) Corrective Action Plan. Non-contracted or Out of Network Providers must be agreeable to rates of payment established with IEHP and not have any documented quality of care concerns in IEHP's systems.[33] (See Attachments, Alternative Access Request – Riverside County" and "Alternative Access Request – San Bernardino County" in Section 14 for currently identified impacted service areas and specialty.)
6. Long-Term Services and Supports (LTSS) – IEHP and its IPAs collaborate with facilities to ensure that Members are placed in Skilled Nursing Facilities (SNFs) or Intermediate Care Facility for the Developmentally Disabled (ICF-DDs), as clinically indicated, within these timeframes:[34]
    a. For Members residing in Riverside County, within seven (7) calendar days of request; or
    b. For Members residing in San Bernardino County, within fourteen (14) calendar days of request.
7. Provider Shortage – If timely appointments within the time or distance standards required are not available, then the IPA shall refer the Member to or assist in locating available and accessible contracted Provider in neighboring service areas to obtain the necessary health care services in a timely manner appropriate for the Member's needs. [35,36] The IPA shall arrange and authorize as appropriate specialty services from specialists outside IEHP's contracted network if unavailable within the network, when medically necessary for the enrollee's condition or when time or distance standards as established by regulators are not met and at no cost to the Enrollee.[37,38] It is important to note that IEHP or its delegated IPAs may not meet Time or Distance Standards for certain zip codes or specialties due to a lack of available Providers with whom to contract in those specific areas but have approved Alternative Access Standards as approved by DHCS.[39] Please see Policy 14D, "Pre-Service Referral Authorization Process" for more information.
8. Telehealth Services – IEHP utilizes telehealth as an option for Members to obtain access to necessary health care services.[40] Please see Policy 18P, "Virtual Care" for more

[32] DHCS APL 21-006
[33] Ibid.
[34] Ibid.
[35] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 3, Access Requirements
[36] KKA, § 1300.67.2.2
[37] Ibid.
[38] NCQA, 2021 HP Standards and Guidelines, MED 1, Element D
[39] DHCS APL 21-006
[40] Ibid.

information.

9. Minimum Hours On-Site – The PCP must be on site and available for Member care a minimum of sixteen (16) hours per week, or meet the criteria identified in Policies 6D, "Residency Teaching Clinics" and 6E, "Rural Health Clinics."

10. Triage, Screening and Advice Services

    a. PCP Offices – All PCP sites must maintain a procedure for triaging or screening Member calls, which, at a minimum, shall include the employment, during and after business hours, of a telephone answering machine and/or an answering service and/or office staff, that will inform the caller: [41,42]

        1) Regarding the length of wait for a return call from the provider; and

        2) How the caller may obtain urgent or emergency care, including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

        Triage services must be provided by a physician, registered nurse , or other qualified health professional acting within their scope of practice and who is trained to screen or triage a Member who may need care.[43] Examples of qualified health professional may include but not be limited to nurse practitioners (NPs) or physician assistants (PA).

    b. After Hours – IEHP provides triage, screening and advice services by telephone 24 hours a day, 7 days a week through its Nurse Advice Line (NAL).[44] By calling the NAL, Members are able to receive assistance with access to urgent or emergency services from an on-call Physician, or licensed triage personnel.[45] Licensed triage personnel use appropriate protocols and sound medical judgment in determining the disposition of the Member (e.g., refer to Urgent Care, Emergency Department). In the event a Member calls a Physician's office after hours, there must be enough access to information on how to proceed, either through an answering service or phone message instructions.[46]

    c. Follow-Up After Accessing the Nurse Advice Line (NAL) – IEHP informs PCPs through the secure Provider portal, when their assigned Member accesses service through the IEHP NAL, including the Member's medical situation and the disposition of the call.

[41] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 3, Access Requirements
[42] KKA, § 1300.67.2
[43] Ibid.
[44] Ibid.
[45] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 3, Access Requirements
[46] KKA, § 1300.67.2.2

11. Telephone Procedures
    a. All PCP offices must have an answering machine and/or answering service during and after business hours. Members who reach voicemail must receive detailed instructions on how to proceed, including but not limited to how to obtain urgent or emergency care.[47]
    b. All PCP offices must have an active and working fax machine twenty-four (24) hours per day, seven (7) days per week. PCP offices that do not have an active and working fax machine should call the Provider Relations Team at (909) 890-2054.
    c. Returning Calls – Provider offices must have a process in place to return Member phone calls.[48] It is understood that the staff member or Physician with whom the Member wishes to speak, may or may not be the party available to return the Member's call. Consequently, the staff member returning the call may or may not be able to definitively address the Member's issue during the call. However, it is expected that the staff member returning the Member's call be prepared to do at least one of the following during that return phone call:
        1) Determine the urgency of the Member's request, solicit more information from the Member if needed, and act accordingly;
        2) Reassure the Member if appropriate;
        3) Agree to pass a message to the Member's Physician or to another relevant staff member if appropriate; and/or
        4) Provide the Member with a timeline or expectation of when the request can be definitively addressed.
    d. Standards for Returning Calls[49] – Provider offices must, at minimum, perform and document three (3) attempts to return Member phone calls within three (3) business days for non-urgent calls and within twenty-four (24) hours for urgent non-emergency calls.
12. Emergency Services - IEHP has continuous availability and accessibility of adequate numbers of institutional facilities, service locations, service sites, and professional, allied, and supportive paramedical personnel to provide covered services including the provision of all medical care necessary under emergency circumstances. IEHP network Physicians and Hospitals must provide access to appropriate triage personnel and emergency services twenty-four (24) hours a day, seven (7) days a week. Please see Policy 14C, "Emergency Services" for more information.

[47] KKA, § 1300.67.2.2
[48] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 3, Access Requirements
[49] Ibid.

a. Follow-up of Emergency Department (ED) Visits – IEHP is responsible for informing PCPs of their assigned Members that receive emergency care, including information regarding needed follow-up, if any. PCPs are responsible for obtaining any necessary medical records from such a visit and arranging any needed follow-up care.[50]

B. **Hospital Standards –** All contracted Hospitals must provide access for Members that need to be admitted for emergency care, inpatient stay, or to utilize hospital-based diagnostic or treatment services.

C. **Special Access Standards**

1. Sensitive Services for Minors and Adults – Providers and Practitioners must have procedures to ensure that minors and adults have access to sensitive and confidential services as outlined in Policy 9E, "Access to Sensitive Services."

2. Access for People with Disabilities – All IEHP facilities and Practitioners are required to maintain access in accordance with the requirements of Title III of the Americans with Disabilities Act of 1990. Each PCP office is assessed to identify if barriers to Member care exist during facility site reviews. Areas audited include but are not limited to: designated parking spaces, wheelchair access, and restroom access for wheelchair users, handrails near toilets, and appropriate signage. If a Provider/Practitioner's office or building is not accessible to Members with disabilities, an alternative access to care must be provided. See Policy 9D, "Access to Care for People with Disabilities."

3. Access and Interpretation Services for People who are Deaf or Hard-of-Hearing and/or with Limited English Proficiency – All IEHP network Providers, including network Pharmacy and Vision Practitioners, must provide services to Members with limited English proficiency in the Member's primary language. See Policies 9H1, "Cultural and Linguistic Services – Foreign Language Capabilities" and 9D1, "Access to Care for People with Disabilities - Members Who Are Deaf or Hard-of-Hearing."

4. Access Standards for Behavioral Health Services – The following information delineates the access standards for availability of services to Medi-Cal Members for Behavioral Health care and after-hours emergency services.

   a. The PCP is responsible for behavioral health/substance use care within his/her scope of practice, otherwise referrals are coordinated through IEHP at (800) 440-4347 or the designated Behavioral Health Plan:

      1) Behavioral health care services are provided by the IEHP BH Program as well as County Mental Health and County Drug and Alcohol treatment programs. Medi-Cal Members who meet specialty mental health criteria are referred to the appropriate county for assessment and treatment. Medi-Cal Members receive annual alcohol misuse screening from their PCP and if screened positive, the

[50] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 7, Emergency Care

Member will receive brief intervention and full screening by the PCP or appropriately qualified Provider. Members needing treatment for alcohol dependence or drug addiction are referred for assessment and treatment to the appropriate County Drug and Alcohol treatment program. During normal business hours referral assistance is available through IEHP or directly through the Mental Health Department in the county where the Member resides. After hours, weekends and holidays, referrals must be coordinated through the County Mental Health Departments.

Riverside County Residents
Community Access, Referrals, Evaluation and Support (CARES) Line
(800) 706-7500

San Bernardino County Residents
San Bernardino County Access Unit
(888) 743-1478

b. Appointment standards:

Behavioral Health[51]	
Type of Visit	**Timeframe**
Life-threatening emergency	Immediate disposition of Member to appropriate care setting
Non-life-threatening emergency	Six (6) hours, or go to the ER
Urgent visit for behavioral health needs that do not require an authorization	Within forty-eight (48) hours of request
Urgent visit for behavioral health need that do require authorization	Within forty-eight (48) hours of request
Initial routine (non-urgent) with a Behavioral Health Care Provider	Within ten (10) business days of request
Follow-up routine (non-urgent) visit	Within ten (10) business days of request
Non-urgent visit with a non-Physician Behavioral Health Provider	Within ten (10) business days of request

c. After Hours Access for Behavioral Health Care:

1) All Behavioral Health Providers are required to have an automated answering system twenty-four (24) hours a day, seven (7) days a week, to direct Members to call 911 or go the nearest emergency room for any life threatening medical or psychiatric emergencies.

[51] NCQA, 2021 HP Standards and Guidelines, NET 2, Element B, Factor 1-4

9. ACCESS STANDARDS

A. Access Standards

Monitoring and Corrective Action Plan Process

A. IEHP monitors network adherence to these access standards through various methods, including but not limited to:

1. On an annual basis, IEHP conducts the Assessment of Network Adequacy Study to assess IEHP's Provider network in areas of Member Experience related to access, access to Providers, and Provider availability such as distribution and ratios. This study uses various sources of data, including but not limited to grievance and appeals data, CAHPS survey data, Annual Behavioral Health Member Experience Survey, Appointment Availability Survey results, and out-of-network data.

2. **Appointment Availability Standards** – On an annual basis, IEHP assesses the network's adherence to appointment availability standards for PCPs, high volume Specialists, Behavioral Health, and Ancillary Providers using the Department of Managed Health Care (DMHC) Provider Appointment Availability Survey (PAAS) Methodology. This methodology includes the use of the DMHC Provider Appointment Availability Survey for PCPs, Specialty Care Physicians and Non-Physician Mental Health Providers. The annual assessment is conducted to monitor the network and act on Providers that are not meeting access standards to bring them into compliance.

   a. For PCPs, the Plan will not perform a sampling of the Providers. Instead, the Plan will survey all active PCPs.

   b. For Specialty Care and Ancillary Care Providers, IEHP will follow the sampling methodology as outlined by the DMHC for.

   Using the DMHC PAAS methodology and tools, IEHP reports on the health plan's overall rate of compliance for each of the time elapsed standards, and that of each IPA in Riverside and San Bernardino Counties (See Attachments, "DMHC Provider Appointment Availability Survey Methodology" and "DMHC Appointment Availability Survey Tools in Section 9). IEHP may utilize a third-party survey vendor to implement all or part of the DMHC PAAS Survey methodology.

3. **Missed Appointments** – The Quality Management Department monitors missed appointments, follow-up, and documentation efforts through the Facility Site Review (FSR) and Medical Record Review (MRR) survey process.

4. **Waiting Times** – The Quality Management Department monitors office wait times through the FSR/MRR survey process. The Provider Relations Team also monitors office wait times by collecting wait time information during the Provider in-service. On a semi-annual basis, all Practitioners are asked to verify office wait time as part of the Provider Directory verification process. On at least an annual basis, the Quality Improvement (QI) Subcommittee reviews the information collected and makes recommendations on actions to take if Practitioners are found to be non-compliant with office wait time standards.

5. **Time or Distance Standards –** On an annual basis, IEHP conducts the Provider Network Status Study to ensure that the health plan is compliant with time, distance, and Provider to Member ratio standards established by the Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), and DMHC, as well as to monitor guidelines provided by the National Committee for Quality Assurance (NCQA). The QI Subcommittee reviews the findings and makes recommendations on actions to take if the health plan is found to be non-compliant with these standards.
6. **Triage, Screening and Advice** – On a monthly basis, IEHP's Family & Community Health Department monitors the Nurse Advice Line's performance and adherence to after -hours triage, screening and advice standards by reviewing triage call center reports. On at least an annual basis, the QI Subcommittee reviews and makes recommendations on actions to take if the NAL provider is found to be non-compliant with triage, screening and advice standards.
7. **Telephone Procedures –** IEHP ensures PCPs have an established and maintained process for answering and returning Member calls through the Facility Site Review (FSR) and Medical Record Review (MRR) survey process. Additionally, all network Providers submit their Provider Information Verification Form as part of the semi-annual Provider Directory verification process. The QI Subcommittee reviews the information collected and makes recommendations on actions to take if Practitioners are found to be non-compliant with telephone answer and return call wait time standards.
8. **Access for People with Disabilities –** IEHP conducts the Physical Accessibility Review Survey (PARS) assessment on PCP, identified high volume Specialist, identified high volume Ancillary sites and all contracted Community Based Adult Services (CBAS) Providers as part of the FSR and MRR process. Information gathered from the PARS assessment are made available to IEHP Members through the IEHP Provider Director and the IEHP website. Please see Policy 6B, "Physical Accessibility Review Survey" for more information.
9. **Access and Interpretation Services for People are Deaf or Hard-of-Hearing and/or with Limited English Proficiency** – The Quality Management Department monitors compliance with these standards through these FSR/MRR survey questions:

   Facility Site Review Questions

   a. There is twenty-four (24)-hour access to interpreter services for non or Limited-English Proficient (LEP) Members.

      1) Interpreter services are made available in identified threshold languages specified for location of site.

      2) Persons providing language interpreter services on site are trained in medical interpretation.

   Medical Record Review Question

a. Primary language and linguistic service needs of non or limited-English proficient (LEP) or hearing-impaired persons are prominently noted.

B. Additional monitoring is performed through the review of grievances and Potential Quality Incidents (PQIs) for individually identified Providers.

C. IEHP reviews results of each audit or study and identifies deficiencies as noted in IEHP policies and procedures. Please see Policy 25A4, "Delegation Oversight – Corrective Action Plan Requirements" for more information regarding the CAP process.

D. IEHP shares with its Delegates the annual plan-wide Appointment Availability and Access Study results. While IEHP does not require Delegates to submit CAPs for identified deficiencies in their network, IEHP does require Delegates to submit their Annual Appointment Availability and After-Hours Access Study program, results, corrective actions taken, follow up call campaigns and proof of Provider training given to remediate any identified deficiencies.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2022

STANDARDS ON INTERPRETER SERVICES

SAMPLE

PURPOSE:

To assure that all sites can provide 24-hour interpreter services for all members either through telephone language services or interpreters on site. This is to ensure that personnel used as interpreters have been assessed for their medical interpretation performance skills/capabilities.

PROCEDURES:

Bilingual Staff

a.) If bilingual staff are asked to interpret or translate, they should be assessed for their qualifications upon hire.
b.) The assessment of ability, training on interpreter ethics/standards, and clear policies that delineate appropriate use of bilingual staff are required to help ensure quality and effective use of resources (e.g.certifications, written policies).
c.) If a Provider is fluent with a certain language, he/she may assess bilingual staff member's ability to interpret by signing an addendum to the Employee Language Skills Self-Assessment Tool (Industry Collaboration Effort Tool).
d.) If the Provider(s) speak the threshold languages and/or have bilingual staff in which the site will utilize for medical translation; the Provider(s) and/or site must have a written policy which includes the languages spoken by the bilingual provider(s) and staff and assessment procedures for qualifications, skills, and capabilities.

Interpreter Services and Translators

a.) Sites utilizing the services of interpreters and translators should request information about certification, assessment taken, qualifications, experience and training of employees.
b.) Sign language interpreter services may be utilized for medically necessary health care services and related services such as obtaining medical history and health assessment, obtaining informed consents and permission for treatments, medical procedure, providing instructions regarding medications, explaining diagnoses, treatment and prognoses of an illness, providing mental health assessment, therapy or counseling.
c.) Sites may access IEHP Interpreter Services by calling:
c.1.) During office hours- Member Services at 1-800-440-4347, TTY users at 1-800-718-4347 c.2.) After Hours- IEHP Nurse Advice Line at 1-888-244-4347, TTY users at 1-866-577-8355. c.3.) Face to Face- Office or member may call the health plan and schedule for an in-person interpreter 5 days prior to member's appointment.

Family or Friends

- Family or friends should not be used as interpreters, unless specifically requested by the member's circumstances. Should a member choose a family member or friend as their interpreter, it must be documented and the interpreter identified in the member's medical record.

It is required that a request for/ or refusal of language/interpreter services must be documented in the member's medical record. (***Note:*** https://www.lep.gov/faqs/faqs.html#OneQ11 ; 22CCR Section 51309.5)

_____ _____

Staff Member's Signature **Date**

_____ _____

Provider's Signature **Date**

EMPLOYEE LANGUAGE SKILLS SELF-ASSESSMENT TOOL

This self-assessment is intended for clinical and non-clinical employees who are bilingual and communicate with a patient in a language other than English.

Employee Name:		Department/Job Title	

Directions:

1) Write any/all languages or dialects you know.
2) Indicate how fluently you speak, read and/or write each language (See attached key).
3) Specify if you currently use the language regularly as part of your job responsibilities.

Language	Dialect, Region Country	Fluency (See key below)			As part of your job do you use this language to speak with patients?	As part of your job do you read this language?	As part of your job do you write this language?
		Speaking 1 low 5 high	Reading 1 low 5 high	Writing 1 low 5 high			
		☐	☐	☐	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
		☐	☐	☐	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
		☐	☐	☐	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
		☐	☐	☐	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Please check off additional qualifications/credentials that support language proficiency level, and attach them to this form. Note: Per state guideline, bilingual providers and staff who communicate with patients in a language other than English must identify and maintain qualifications of their bilingual capabilities on file.

☐ Formal language assessment by qualified agency
☐ Native speaker with a higher education in language
☐ Documentation of successful completion of a specific type of interpreter training
☐ Documentation of years employed as an interpreter and/or translator
☐ Other (Please specify):

Individuals, who rate themselves with speaking, reading, or writing capabilities below level 3 as defined on the Employee Skills Self-Assessment Key, should not use their bilingual skills or serve as interpreters and/or translators. For assistance, please contact the patient's contracted health plan for immediate telephonic interpreter assistance.

TO BE SIGNED BY THE PERSON COMPLETING THIS FORM

Signature **Date**

Employee Language Skills Self-Assessment Key

Key	Spoken Language
1	Satisfies elementary needs and minimum courtesy requirements. Able to understand and respond to2-3 word entry-level questions. May require slow speech and repetition.
2	Meets basic conversational needs. Able to understand and respond to simple questions casual conversation about work, school, and family. Has difficulty with vocabulary and grammar.
3	Able to speak the language with sufficient accuracy and vocabulary to have effective for informal conversations on most familiar topics related to health care.
4	Able to use the language fluently and accurately on all levels related to health care work needs. Can understand and participate in any conversation within the range of his/her experience with a high degree of fluency and precision of vocabulary. Unaffected by rate of speech.
5	Speaks proficiently equivalent to that of an educated native speaker. Has complete fluency in the language, including health care topics, such that speech in all levels is fully accepted by educated native speakers in all its features, including breadth of vocabulary and idioms, colloquialisms, and pertinent cultural preferences. Usually has received formal education in target language.

Key	Reading
1	No functional ability to read. Able to understand and read only a few key words.
2	Limited to simple vocabulary and sentence structure.
3	Understands conventional topics, non-technical terms and heath care terms.
4	Understands materials that contain idioms and specialized health care terminology; understands a broad range of literature.
5	Understands sophisticated materials, including those related to academic, medical and technical vocabulary.

Key	Writing
1	No functional ability to write the language and is only able to write single elementary words.
2	Able to write simple sentences. Requires major editing.
3	Writes on conventional and simple health care topics with few errors in spelling and structure.
4	Writes on academic, technical, and most health care and medical topics with few errors in structure and spelling.
5	Writes proficiently equivalent to that of an educated native speaker/writer. Writes with idiomatic ease of expression and feeling for the style of language. Proficient in medical, healthcare, academic and technical vocabulary.

Interpretation VS. Translation	**Interpretation:** Involves spoken communication between two parties, such as between a patient and a pharmacist, or between a family member and doctor. **Translation:** Involves very different skills from interpretation. A translator takes a written document in one language and changes it into a document in another language, preserving the tone and meaning of the original. *Source: University of Washington Center*

Addendum to Employee Language Skills Self-Assessment Tool

(Provider Name and/or Clinic Name) Use the Employee Language Skills Self-Assessment Tool (Industry Collaboration Effort Tool) to assess the medical translation skills of our employees. I attest that (Name of Personnel) has demonstrated the ability to effectively perform the procedures stated in this document.

_____ _____

Printed Name Provider's Signature/Date

Inland Empire Health Plan

PCP Referral Tracking Log

Date of Service	Date Referral Sent to IPA & Name of IPA	Member Name & Date of Birth	Acuity of Referral (Urgent or Routine)	Reason for Referral/Dx	Service or Activity Requested	Date Auth. Received	Referral Decision** (Approved or Denied/Partially Approved (Modified))	Date Patient Notified	Date Appt or Service	Date of Consult Report Received	Outreach Documentations
			❑ Routine ❑ Urgent				❑ Approved ❑ Denied or Partially Approved (Modified)				1st 2nd 3rd
			❑ Routine ❑ Urgent				❑ Approved ❑ Denied or Partially Approved (Modified)				1st 2nd 3rd
			❑ Routine ❑ Urgent				❑ Approved ❑ Denied or Partially Approved (Modified)				1st 2nd 3rd
			❑ Routine ❑ Urgent				❑ Approved ❑ Denied or Partially Approved (Modified)				1st 2nd 3rd
			❑ Routine ❑ Urgent				❑ Approved ❑ Denied or Partially Approved (Modified)				1st 2nd 3rd
			❑ Routine ❑ Urgent				❑ Approved ❑ Denied or Partially Approved (Modified)				1st 2nd 3rd
			❑ Routine ❑ Urgent				❑ Approved ❑ Denied or Partially Approved (Modified)				1st 2nd 3rd

SAMPLE

FAX

SAMPLE

TO:	FROM:
FAX:	FAX:
PHONE:	PHONE:
SUBJECT:	DATE:
NO. PAGES:	

COMMENTS:

SAMPLE

Authorization to Release Medical Information

Patient Name:	
Date of Birth:	
Phone Number:	

I hereby authorize _____to disclose my health records to
(former physician's office)

_____ for continuation of my medical care.
(recipient of medical records)

☐	Entire Record:
☐	Specific Information:
☐	Other:

Please send the medical record information to:

Physician's Name:	
Phone Number:	
Address:	
Fax Number:	

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on authorization. Unless otherwise revoked, **this authorization will expire 90 days from the date the authorization was signed**. The facility, its employees, and physicians are hereby release from legal responsibly or liability from disclosure of the above information to the extent indicated and authorized herein

PATIENT SIGNATURE: _____ DATE: _____

LEGAL GUARDIAN _____ DATE _____

SAMPLE

PATIENT DISTIBUTION LOG

MEDICATION/FORMULAS SAMPLES

DATE DISPENSED	PATIENT/DOB	DRUG/FORMULA	LOT #	# BOXES/BOTTLES & DOSES	EXP DATE	SIGNATURE OF DISPENSER	PRESCRIBER

SAMPLE

Controlled Substance Distribution Log

Name of Drug	MD/NP/PA DEA #	Date	Original Qty.	Dose Given / Doses Remaining	Patient Name	Name of Distributing Provider
				/		
				/		
				/		
				/		
				/		
				/		
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SAMPLE

Distribution of Sample Medications/Formula

PURPOSE: Compliance with providing sample medications/formulas to patients in a safe manner requires a significant administrative effort. The physician office will practice dispensing sample medications/formulas to its patients, the practice will act as a pharmacy and is required to follow state and federal pharmacy regulations. The physician's office will address the following areas in: accepting and distributing sample medications/formulas to assure the physician's responsibility to the patient and the regulatory system has been met.

POLICY: The physician's office will address the following areas in: accepting and distributing sample medications/formulas to assure the physician's responsibility to the patient and the regulatory system such as keeping a Destruction and Expiration Log, Inventory Inspection Log, Refrigerator/Freezer Log, Patient Distribution Log, Patient Instruction Form.

PROCEDURE:

I. Accepting Samples

A. All sample medications/formulas received from a pharmaceutical drug representative should be documented as received on a Drug Inventory Log, initialed by both the pharmaceutical drug representative and an office staff member. Pharmaceutical drug representatives should not be independently accessing samples and should be accompanied by staff when accessing the samples.

II. Storage and Documentation

A. The practice is responsible for having a process in place for the storage, handling, removal, and distribution of samples. A specific person should be assigned responsibility for inspections, preferably, monthly.
B. All sample medications/formulas should be stored in a locked room in a location inaccessible to patients. Medications/formulas should not be stored in exam rooms where patients are left unattended.
C. The storage area should not be subject to extreme temperatures. All refrigerators containing medications/formulas should have daily temperature checks. For medications/formulas requiring refrigeration, processes need to be in place to notify if there has been a refrigerator or freezer (electricity malfunction when the office is closed. Logs of these checks should be maintained for five years.
D. Lighting in the storage room should allow easy reading of medication names and dosages.
E. Samples should be well-organized by drug or drug group. Medications/formulas with similar names or similar packaging should be located in separate areas.
F. All medications/formulas in the practice should be stored according to manufacturer's instructions. They should be checked monthly for outdates, deterioration and appropriate location. Inspect all areas in which medications/formulas are stored including refrigerators.
G. It is recommended that an inventory of sample medications/formulas be maintained. It may be helpful to use an inventory sheet for each type of sample medication. Maintain the log on file for five years. These sample logs are intended to provide your office practice with a methodology to track the sample medications/formulas that you dispense as well as aid you in identifying those that have expired and require disposal.
    1. The EXPIRATION AND DESTRUCTION LOG allows you to document expired medications/ formulas when it is destructed by a pharmacy. When sample medications/formulas is destructed at a pharmacy, a pharmacist must sign off on the receiving sample medications/ formulas on Expiration and Destruction Log. Expired sample medications/formulas should be discarded in accordance with federal, state and local laws. Drug take-back programs may be an alternative for practices to remove unwanted medicines from the practices. It is important to contact your state or the federal Department of Environmental Services for advice on medication disposal.
    2. The INVENTORY INSPECTION LOG allows you to check all expiration dates at a glance to streamline your review and discard process.
    3. The REFRIGERATOR/FREEZER TEMPERATURE LOG is a log to assist you in compiling the necessary temperature documentation for medications/formulas requiring refrigeration.
    4. The PATIENT DISTRIBUTION LOG is a means to keep track of the patients who received the medication, along with the lot number of that medication. Use of this log will simplify the process of identifying your patients that have received a medication whose lot number has been recalled or has had other warnings or issues associated with it.
    5. The provider must provide all the necessary drug information, patient instructions, education, and documented in member's list.

III. Access

A. Sample medications/formulas should be stored in a secured location. Access to sample medications/formulas should be limited to specified medical personnel only.

B. Employees should not be allowed to access or request free samples. Self-medication can lead to adverse events of which the practice could be held liable.

IV. Dispensing

A. Only pharmacists, physicians and mid-level providers with prescribing authority may actually dispense medications/formulas. When the physician office practice dispenses sample medications/formulas to its patients, the practice is acting as a pharmacy and is required to follow state and federal pharmacy regulations.

B. At times patients request refills of their sample medications/formulas. Sample medications/ formulas may only be dispensed **after** a physician or mid-level provider with prescribing authority (physician assistant or nurse practitioner) has authorized the refill. This information should be noted in the patient's record.

C. When retrieving sample medications/formulas, the authorized medical professional should:
   1. Review the provider's order/authorization
   2. Double check the name of the medication on the package
   3. Confirm the expiration date of the medication
   4. Verify the patient's allergies to medications/formulas

D. All medications/formulas should be labeled with the following:
   1. Patient's Name
   2. Medication Name
   3. Dosage
   4. Frequency or Time
   5. Route
   6. Form, i.e., liquid, tablet, drops
   7. Date Dispensed
   8. Lot Number

E. The provider should discuss with the patient the administration, storage, potential interactions, and side effects of the medication. All discussions with the patient regarding allergies, side effects, dosage, special procedures for taking medications/formulas and other related issues should be documented in the patient's medical record.

F. A SAMPLES DRUG FORM is a form for providing the medication information patient's may need after they leave the practice, as patients may not remember oral instructions. The form provides a place for patient/guardian signature acknowledging receipt of the medication information. A copy of this form should be retained in the patient's medical record.

G. A double check of the patient's name and second identifier, i.e., date of birth, should occur when providing the patient with the medications/formulas.

H. Documentation of the provision of sample medications/formulas should be placed in the patient's medical record to include the name of the medication, date, dose, frequency, route, form, date dispensed, lot number and written authorization by the provider. Any written information provided to the patient regarding the instructions and adverse reactions of medications/formulas prescribed should also be noted in the patient's medical record.

All physician practices that distribute sample medications/formulas should ensure mechanisms are in place for secure storage, patient distribution and education, appropriate record-keeping and regular monitoring. A detailed policy and procedure should support this process.

Temperature Log

Month & Year _____ **Provider PIN** _____

Storage Unit Location/ID	**Scale** ☐ Fahrenheit ☐ Celsius	**Storage Unit Type** (select one) ☐ **Refrigerator** (36º to 46ºF / 2º to 8ºC) ☐ **Freezer** (-58º to 5ºF / -50º to -15ºC) ☐ **ULT** (-130º to -76ºF /- 90º to -60ºC)
Funding Source(s) ☐ VFC ☐ VFA ☐ LHD 317 ☐ SGF ☐ Private ☐ _____		

Day	Time	Initials	Alarm	Current	Min	Max	Excursion #
Example	8:00 am	NN		40.5	38.1	43.7	
	4:00 pm	NN	✔	37.4	33.0	39.2	12345
1	am						
	pm						
2	am						
	pm						
3	am						
	pm						
4	am						
	pm						
5	am						
	pm						
6	am						
	pm						
7	am						
	pm						
8	am						
	pm						
9	am						
	pm						
10	am						
	pm						
11	am						
	pm						
12	am						
	pm						
13	am						
	pm						
14	am						
	pm						
15	am						
	pm						

Check temperatures twice a day:

1. Fill out clinic/unit details in header.
2. Record the time and your initials.
3. Record a check if alarm went off.
4. Record Current, MIN, and MAX.
5. Clear MIN/MAX on your device.
6. Ensure data logger is recording.

IF ALARM WENT OFF:

1. Clear MIN/MAX and alarm symbol.
2. Post "Do Not Use Vaccines" sign.
3. Alert your supervisor.
4. Report excursion at myCAvax for all funding sources.
5. Record myCAvax Batch Excursion # in last column or in notes.
6. Ensure data logger is recording.

On-Site Supervisor's Review

When complete, check all that apply:

☐ Temperatures were recorded twice daily.

☐ I reviewed data files to find any missed excursions.
Download date: _____

☐ Any excursions were reported.

On-Site Supervisor's Name:

_____

Signature: _____

Date: _____

Staff Names and Initials:

_____

_____

Additional excursion notes:

_____

_____

_____

_____

Keep all temperature logs and data files for three years.
Falsifying log is grounds for vaccine replacement and program termination.

Temperature Log

Month & Year _____ **Provider PIN** _____

Storage Unit Location/ID	**Scale** ☐ Fahrenheit ☐ Celsius	**Storage Unit Type** (select one) ☐ **Refrigerator** (36º to 46ºF / 2º to 8ºC) ☐ **Freezer** (-58º to 5ºF / -50º to -15ºC) ☐ **ULT** (-130º to -76ºF /- 90º to -60ºC)
Funding Source(s) ☐ VFC ☐ VFA ☐ LHD 317 ☐ SGF ☐ Private ☐ _____		

Day	Time	Initials	Alarm	Current	Min	Max	Excursion #
16	am / pm						
17	am / pm						
18	am / pm						
19	am / pm						
20	am / pm						
21	am / pm						
22	am / pm						
23	am / pm						
24	am / pm						
25	am / pm						
26	am / pm						
27	am / pm						
28	am / pm						
29	am / pm						
30	am / pm						
31	am / pm						

Check temperatures twice a day:

1. Fill out clinic/unit details in header.
2. Record the time and your initials.
3. Record a check if alarm went off.
4. Record Current, MIN, and MAX.
5. Clear MIN/MAX on your device.
6. Ensure data logger is recording.

IF ALARM WENT OFF:

1. Clear MIN/MAX and alarm symbol.
2. Post "Do Not Use Vaccines" sign.
3. Alert your supervisor.
4. Report excursion at myCAvax for all funding sources.
5. Record myCAvax Batch Excursion # in last column or in notes.
6. Ensure data logger is recording.

On-Site Supervisor's Review

When complete, check all that apply:

☐ Temperatures were recorded twice daily.

☐ I reviewed data files to find any missed excursions.
Download date: _____

☐ Any excursions were reported.

On-Site Supervisor's Name:

_____

Signature:_____

Date: _____

Staff Names and Initials:

_____

_____

Additional excursion notes:

_____

_____

_____

_____

Keep all temperature logs and data files for three years.
Falsifying log is grounds for vaccine replacement and program termination.

*****SAMPLE*****

Plan for Vaccine Protection in Case of Power Outage or Malfunction of the Refrigerator or Freezer

- Do not open freezers and refrigerators until power is restored.
- Most refrigerated vaccines are relatively stable at room temperature for limited periods of time. The vaccines of most concern are MMR and Varivax, which are sensitive to elevated temperatures.
- **Monitor temperatures; don't discard; don't administer affected vaccines until you have discussed with public health authorities.**
- If the power outage is on-going:
  1. Keep all refrigerators and freezers closed. This will help to conserve the cold mass of the vaccines.
  2. Continue to monitor temperatures if possible. Do not open units to check temperatures during the power outage. Instead, record the temperature as soon as possible after the power is restored, and the duration of the outage. This will provide data on the maximum temperature and maximum duration of exposures to elevated temperatures.
  3. If alternative storage with reliable power sources are available (i.e., hospital with generator power), transfer to that facility can be considered. If transporting vaccine, measure the temperature of the refrigerator(s) and freezer(s) when the vaccines are removed. If possible transport the vaccine following proper cold chain procedures for storage and handling or try to the record the temperature the vaccine is exposed to during transport.
- When power has been restored:
  1. Record the temperature in the unit as soon as possible after power has been restored. Continue to monitor the temperatures until they reach the normal 2–8 degrees Celsius range in the refrigerator, or -15 degrees C or less in the freezer. Be sure to record the duration of increased temperature exposure and the maximum temperature observed.
  2. If you receive vaccine from your state or local health department, they may be contacting you with guidance on collecting information on vaccine exposed to extreme temperatures.
  3. If you are concerned about the exposure or efficacy of any of your vaccine stock, do not administer the vaccine until you have consulted your state or local health department.
  4. Keep exposed vaccine separated from any new product you receive and continue to store at the proper temperature if possible.
  5. Do not discard any potentially exposed vaccine. We will be working with the vaccine manufacturers to determine which vaccines may be viable.

For additional information about vaccine storage during a power outage, see the guidance provided by the CDC National Immunization Program at www.cdc.gov/nip/news/poweroutage.htm or contact your state or local health department.

For more information, visit www.bt.cdc.gov/disasters, or call CDC at 800-CDC-INFO (English and Spanish) or 888-232-6348 (TTY).

SAMPLE

Vaccine Information Sheet (VIS) Protocol

Procedure: (Any of the list below is acceptable)

- Paper Copies of the VIS can be printed and given to patients prior to vaccinations
- Permanent, laminated office copies may be given to patients to read prior to vaccination (must offer most recent publication)
- Patients may view VIS on a computer monitor or other video display
- Patients may read the VIS on their phone or other digital device by downloading the pdf file from CDC's website (see Link below)
- Patients may be given a copy of a VIS during a prior visit, or told how to access it through the internet, so they can read it in advance. These patients must still be offered a copy to read during the immunization visit as a reminder.
- Patients must still be offered a copy of the VIS to take away following the vaccination. The patients may decline

SAMPLE

Glucometer Quality Control Log

High/Low Controls

Month: _____ Year: _____

Purpose: To Verify and Document Performance of Glucose Meter and Maintenance Documentation.

Control Solutions – Acceptable Ranges:

Low Control Solution:
Lot # _____
Exp. Date: _____
Acceptable Ranges:
_____to_____
HIGH LOW

High Control Solution:
Lot # _____
Exp. Date: _____
Acceptable Ranges:
_____to_____
HIGH LOW

Date	High	Low	Within Range Yes or No	Initials	Comments
1			Yes or No		
2			Yes or No		
3			Yes or No		
4			Yes or No		
5			Yes or No		
6			Yes or No		
7			Yes or No		
8			Yes or No		
9			Yes or No		
10			Yes or No		
11			Yes or No		
12			Yes or No		
13			Yes or No		
14			Yes or No		
15			Yes or No		
16			Yes or No		
17			Yes or No		
18			Yes or No		
19			Yes or No		
20			Yes or No		
21			Yes or No		
22			Yes or No		
23			Yes or No		
24			Yes or No		
25			Yes or No		
26			Yes or No		
27			Yes or No		
28			Yes or No		
29			Yes or No		
30			Yes or No		
31			Yes or No		

SAMPLE

Hemocue Hb 201+ Quality Control Log Sheet

Month _____ Year _____

QC Data: This area must be completed during the first clinic of each month. If any items expire during the month, or a new bottle is opened, it must be documented. The package insert will specify the open vial expiration date. *If Hemocue Hb Self-Calibrate have manufacturer guide available.*

	Lot number	Closed vial expiration date	Open vial expiration date	Expected Range
Low Control				to
High Control				to
Cuvette Bottle				N/A

Q.C. Results

Date	**Hemacue Cleaned (yes/no)** **(Each day of use)**	**SELFTEST (Pass/Fail)** (Each day of use)	**Low Control (weekly)**	**High Control (weekly)**	**Weekly Controls (Pass/Fail)**	**Initials**

LOS ANGELES COUNTY HEALTH AGENCY

COUNTY OF LOS ANGELES
Public Health

BARBARA FERRER, Ph.D., M.P.H., M.Ed.
Director

JEFFREY D. GUNZENHAUSER, M.D., M.P.H.
Interim Health Officer

CYNTHIA A. HARDING, M.P.H.
Chief Deputy Director

ANGELO J. BELLOMO, REHS, QEP
Deputy Director for Health Protection

TERRI S. WILLIAMS, REHS
Director of Environmental Health

BRENDA J. LOPEZ, REHS
Assistant Director of Environmental Health

5050 Commerce Drive
Baldwin Park, California 91706
TEL (626) 430-5374 • FAX 16261 813-3000

DATE

ADDRESS

SAMPLE

Attention:

INSPECTION OF X-RAY REGISTRATION, NUMBER

Dear Dr. :

On _____, this office conducted an inspection of your X-ray facilities as they relate to radiation safety, compliance with the Health and Safety Code, and the California Code of regulations, title 17. All items were in compliance.

Thank you for your cooperation. If you have any questions regarding the inspection, or this report, you may call this office at (213) 351-7379.

Very truly yours,

Senior Radiation Protection Specialist

Approved:

Principal Radiation Protection Specialist

Help us serve you better by completing a short survey.
Visit our website at www.publichealth.lacounty.gov/eh

SAMPLE

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

NOTICE TO EMPLOYEES

STANDARDS FOR PROTECTION AGAINST RADIATION

CALIFORNIA RADIATION CONTROL REGULATIONS (CALIFORNIA CODE OF REGULATIONS, TITLE 17, SECTION 30255)

The California Radiation Control Regulations include standards for protection against radiation hazards. The California Department of Public Health has primary responsibility for administering these standards which apply to both employers and employees. Enforcement is carried out by the California Department of Public Health or its authorized inspection agencies.

EMPLOYEES' RESPONSIBILITIES

You should know and understand those California radiation protection standards and your employer's operating and emergency procedures which apply to your work. You should comply with these requirements for your own safety and the safety of others. Report promptly to your employer any condition which may lead to or cause a violation of these standards or employer's operating and emergency procedures.

SCOPE OF THE STANDARDS

The Standards for Protection Against Radiation define:

1. Limits on exposure to radiation and radioactive materials;
2. Actions to be taken after accidental exposure;
3. Working conditions requiring personnel monitoring, safety surveys, engineered controls, and safety equipment;
4. Proper use of caution signs, labels, and safety interlock devices;
5. Requirements for keeping worker exposure records and reporting of such exposures;
6. The requirement for specific operating and emergency procedures for radiation work; and
7. The rights of workers regarding safety inspections.

EMPLOYERS' RESPONSIBILITIES

Your employer is required to:

1. Comply with the requirements of the California Radiation Control Regulations, departmental orders, and license conditions;
2. Post or make available to you copies of the Radiation Control Regulations, any license issued thereunder, and your operating and emergency procedures;
3. Post any notice of violation of radiological working conditions; and
4. Provide you with information on your exposure to radiation.

REPORTS ON YOUR RADIATION EXPOSURE HISTORY

1. California Radiation Control Regulations require your employer to give you a written report if you receive an exposure greater than the limits set in the radiation safety standards. Basic limits for occupational radiation exposure can be found in section 30253 referencing title 10, Code of Federal Regulations, part 20 (10 CFR 20). Limits on exposure to radiation and exposure to concentrations of radioactive material in air are specified in 10 CFR 20, subpart C.
2. If the radiation protection standard, under 10 CFR 20 (subpart F) requires that your radiation exposure be monitored, your employer must, upon your request, give you a written report of your exposures upon termination of your employment, and make available to you the information in your dose records (as maintained under the provisions of 10 CFR 20.2106).
3. Your employer is required to provide you with an annual report of the dose you received in that monitoring year if the dose exceeds 100 millirem, or if you request an annual report.

INSPECTIONS

The Department or one of its contractors will inspect your workplace from time to time to ensure that health and safety requirements are being followed and that these requirements are effective in protecting you. Inspectors may confer privately with you at the time of inspection. At that time you may direct the inspector's attention to any condition you believe is or was a violation of the safety requirements.

In addition, if you believe at any time that any health and safety requirements are being violated, you or your workers' representative may request that an inspection be made by sending a complaint to the Department of Public Health or other official agency. Your complaint must describe the specific circumstances of the apparent violation and must be signed by you or your workers' representative. The Department is required to give your employer a copy of any such complaint. Names may be withheld at your request. You should understand, however, that the law protects you from being discharged or discriminated against in any way for filing a complaint or otherwise exercising your rights under the California Radiation Control Regulations.

POSTING REQUIREMENTS

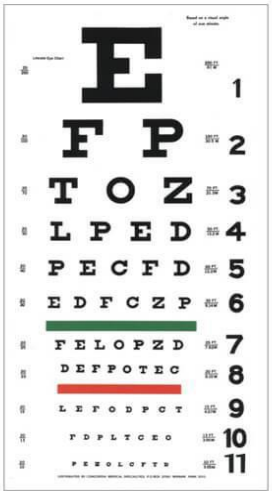
Copies of this notice must be posted in a sufficient number of places in every establishment where employees are employed in activities regulated by the California Radiation Control Regulations, to permit employees working in or frequenting any portion of a restricted area to observe a copy on the way to or from their place of employment.

FOR RADIOLOGICAL EMERGENCY ASSISTANCE (24/7), PHONE 1-800-852-7550
To contact the Radiologic Health Branch, phone (916) 327-5106
or go to the Radiologic Health Branch (https://www.cdph.ca.gov/rhb)

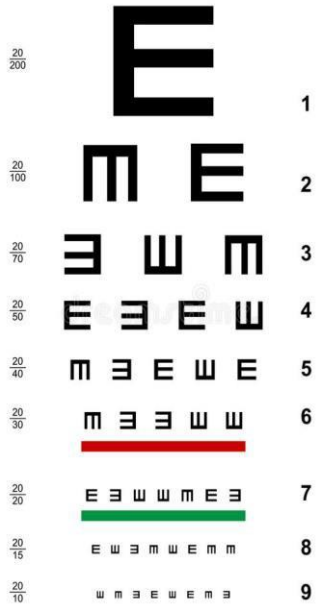
*****SAMPLE*****

Required Eye Charts :

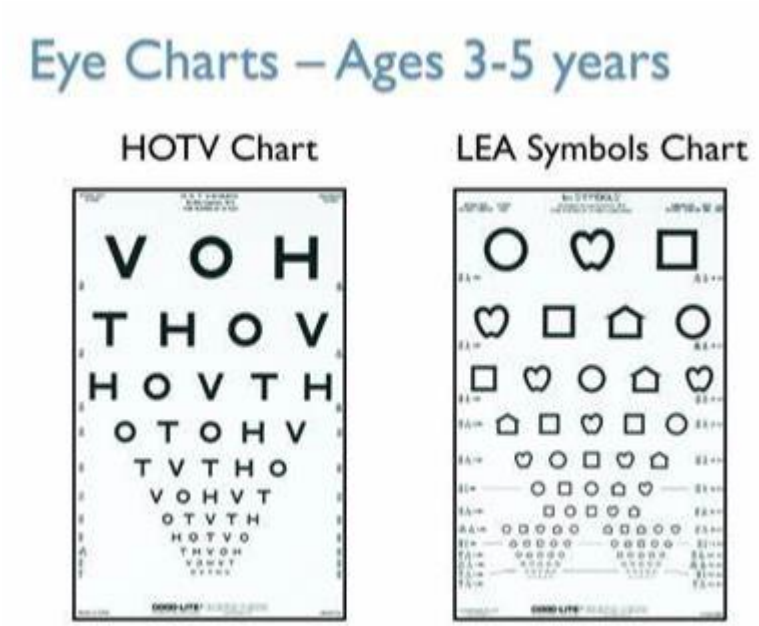
Literate



Illiterate: Adults



Pediatric Eye charts



- For children 10 and under, they must have an occluder that they cannot hold such as an eye patch or 2" hypoallergenic paper tape.
- Wall mounted eye charts should be height adjustable and positioned at the eye level of the patient.

VISUAL ACUITY SCREENS

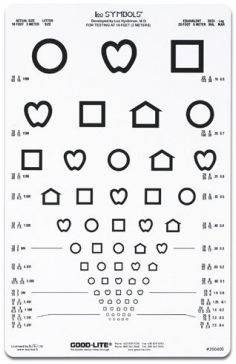
FREQUENCY: Ages 3, 4, 5, 6, 8, 10, 12, and 15 years old

Per AAP Bright Futures Recommendations for Preventive Pediatric Health Care

SCREENING TOOLS

3-5 years old

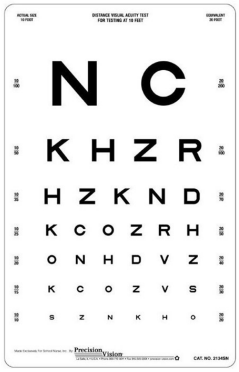
LEA Symbols



HOTV Letters

5 years old and up

Sloan Letters



OCCLUDERS

Under 10 years of age

Single use adhesive eye patch or reusable hard plastic eye patch

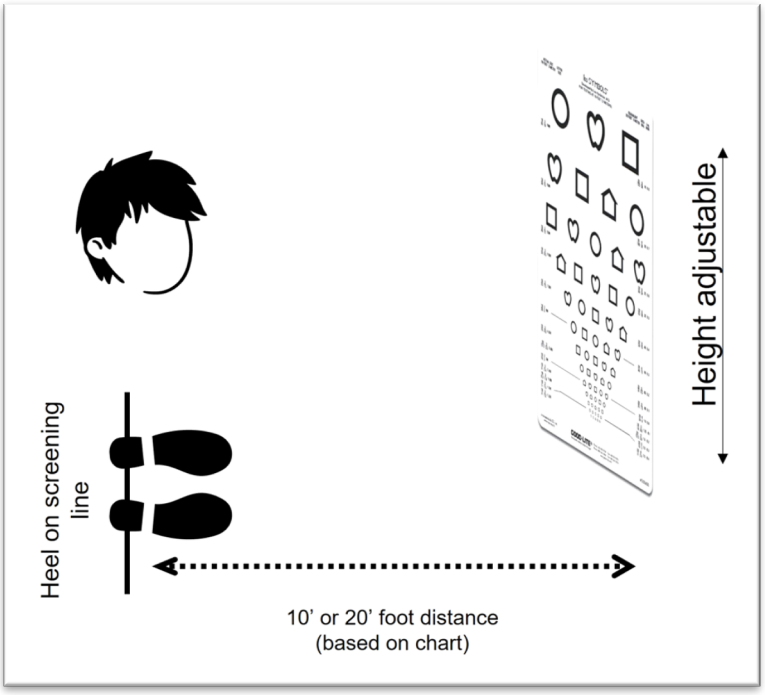
Occluder glasses acceptable if patch/tape not tolerated

10 years and older

Patch/tape preferred but can use handheld paddle occluder

KEY POINTS

- ⇒ Well-illuminated area free from distraction
- ⇒ Screening line should be marked on the floor and directly in front of chart
- ⇒ Eye chart should be at child's eye level
- ⇒ Child should place heel on screening line
- ⇒ If child wears prescription eyeglasses, screen with glasses on
- ⇒ If unable to screen on first attempt, make second attempt during same visit, if still unable to screen, schedule another visit to screen or refer to optometrist



Revised 6/2023

****SAMPLE of Different Types of Pure Tone Audiometer*****

SAMPLE

Policy and Procedure: Appropriate handling and transport of contaminated equipment and/or instruments

Purpose: To prepare contaminated instruments for transport:

1. All individuals with potential contact with the instruments have been given the required Blood Borne Pathogens training.

2. The instruments are sprayed with an enzymatic foam. Point-of-use cleaning is required to remove blood/body fluids prior to transport.

3. The contaminated instruments are placed into a puncture resistant, plastic container with a lid that is marked with an approved biohazard label.

4. The container is then transported to _____ for processing.

State of California—Health and Human Services Agency
California Department of Public Health

KAREN L. SMITH, MD, MPH
Director and State Public Health Officer

EDMUND G. BROWN JR.
Governor

Reusable Container Systems for Sharps Waste and Pharmaceutical Waste

Biomedical Waste Disposal, Inc.

Alik Ghazaryan
SharpsAway™ (877) 644-2424

Daniels Sharpsmart, Inc.

David Skinner
Daniels Sharpsmart™ (805) 907-1160

Medical Waste Services

Terry Shain
SharpsAway™ (888) 610-1311

MediWaste Disposal LLC

Ryan Oganesian
Rehrig Healthcare Systems Sharps Tank® (855) 449-MEDI (6334)

Pacific Medical Waste

Victor DiVello
SharpsAway™ (602) 305-8888

PRIMA Waste Management

SharpsAway™ (562) 246-1250

Stericycle, Inc.

Bio Systems™ (866) 338-5120

Waste Management Healthcare Solutions

Rehrig Healthcare Systems Sharps Tank® (323) 807-0557

Disclaimer
This listing does not carry any expressed or implied endorsement by the Medical Waste Management Program for any reusable container system.

Safety&Health Fact Sheet

CONSULTATION CAL OSHA SERVICE

July 1999

Cal/OSHA Consultation Service
California Department of Industrial Relations
P. O. Box 420603 ▪ San Francisco, CA 94142-0603

Safety Needles & Needleless Systems

Bloodborne Pathogens Regulation Changes

New Cal/OSHA requirements intended to reduce needlesticks and other "sharps" injuries that can cause exposure to bloodborne pathogens took full effect on July 1, 1999. **An easy-to-read version of the revised regulation is available from the Cal/OSHA Consultation Service.**

Why was the regulation changed?

The recent changes to Section 5193 came about in response to:

- Continuing high numbers of needlestick and other sharps injuries in health care settings.
- Recognition of hepatitis C as a bloodborne pathogen of serious concern.
- Emerging technologies for needleless systems, and needles and other sharps devices with "engineered sharps injury protection" (e.s.i.p.).

Major elements of the revisions:

- New requirements for use of needleless systems and sharps devices with e.s.i.p., subject to four exceptions.
- New requirements for a program to evaluate and select needleless systems and sharps devices with e.s.i.p. appropriate for procedures conducted, with active involvement of frontline health care providers.
- Maintenance of a Sharps Injury Log.
- Addition of hepatitis C as a specifically named bloodborne pathogen.
- Reorganization of existing requirements for greater clarity, and a number of other changes.

Employers affected by these changes:

Health care providers continue to be the primary focus of Section 5193. The new requirements focus on employees conducting the following medical procedures:

- Withdrawal of body fluids.
- Accessing a vein or artery.
- Administration of medications or fluids.
- Any other procedure with potential for a sharps injury exposure incident.

Other employers who remain covered by the regulation include emergency and public safety services, correctional and custodial care facilities, and providers of services to any of these covered employers—such as plumbers and laundry—whose employees could be exposed to bloodborne pathogens. Employers whose employees may be reasonably anticipated to have occupational exposure to bloodborne pathogens are also covered, as are employees providing first aid.

What if safer devices are not available or could compromise patient care?

The goal of the new requirements is to protect employees without compromising patient safety or care. Practicing medical professionals helped draft the revisions. To address availability, patient care and other issues, there are four exceptions to the new requirements:

- Employer shows that no needleless systems or sharps devices with e.s.i.p. are available in the marketplace for their procedure.
- A licensed health care professional directly involved with a patient's care determines that available needleless systems or sharps devices with e.s.i.p. would compromise the patient's care or safety.
- Employer shows that available needleless systems and sharps devices with e.s.i.p. are not more effective in preventing exposure to bloodborne pathogens than the alternative they are using.
- Employer shows that sufficient information is not available on the safety performance of needleless systems or sharps devices with e.s.i.p. available in the marketplace, and the employer is actively evaluating such devices.

Where do we start?

Employers who have not yet begun converting to needleless systems and sharps devices with e.s.i.p. should focus **immediately** on coming into compliance by:

- Evaluating records of sharps injuries, talking with employees, and addressing areas where the frequency and consequences of exposure are greatest.
- Evaluating and selecting devices for the highest risk areas, then establishing the program—including maintenance of the required Sharps Injury Log—for all covered procedures.
- Documenting the above activities.

Cal/OSHA Consultation Service Offices

For telephone assistance and to request a no-cost consultation at your worksite:

Sacramento 916-263-0704
Oakland 510-622-2891
Van Nuys 818-901-5754
San Diego/San Bernardino/Anaheim 714-935-2750
Or toll-free **1-800-963-9424**

Questions asked frequently

Q. What does "engineeered sharps injury protection" (e.s.i.p.) mean?

A. As defined in the regulation, e.s.i.p. is a physical attribute that is built into a needle or other sharps device which effectively reduces the risk of a blood-borne pathogens exposure incident. Examples: devices which blunt, sheath, or withdraw the sharp.

Q. Would devices that facilitate safer recapping or disposal of sharps qualify as engineered sharps injury protection?

A. No. To qualify as e.s.i.p. the attribute must be an integral part of the sharps device. The ultimate intention, where any sharps device is used, is that it be guarded before—or as soon as possible after—removal from the patient or other source of blood or infectious material.

Q. Can I choose between a needleless system and a sharps device with e.s.i.p. if both are available for a particular procedure?

A. No. Where this choice is available, the needleless system must be used. Devices with e.s.i.p. are acceptable only where no satisfactory needleless system is available.

Q. Is a needleless system or sharps device with e.s.i.p. now required even when a doctor or nurse determines that it could compromise patient care or safety?

A. No. This is one of the exceptions to the new requirements. However, this exception is allowed only where a licensed health care professional directly involved in the patient's care has made and documented the determination, as required in the regulation.

Q. Can we use up our supply of traditional sharps devices?

A. Yes, but **only** where the required safer alternatives are not available, or one of the exceptions applies.

Q. We have completed our evaluation and selection process, including active involvement of affected employees, and have decided on the needleless system and sharps devices with e.s.i.p. that we want to use. However, our vendor has told us that several of the devices are temporarily out of stock. What do we do now?

A. Cal/OSHA recognizes that these major new requirements may cause temporary shortages of some devices, and will take this into account in enforcement actions. If the vendor delay is likely to be lengthy, alternative suppliers should be used. Just as with any device critical to continued patient care and employee safety, alternative devices and suppliers should be evaluated, selected and maintained as a back-up source.

Q. Is a device with engineered sharps injury protection that has been activated still required to be disposed of as sharps waste?

A. Yes. Because some devices can be defeated or deactivated, sharps with activated safety devices must still be disposed of as sharps waste.

Q. Do the new requirements apply to sharps other than needles?

A. Yes. The revised regulation contains a new definition of sharps in general, and requires that non-needle sharps be used which incorporate engineered sharps injury protection, subject to the four exceptions.

Q. Where can I get additional help with understanding the new requirements?

A. A number of Internet resources are listed below. You can also obtain free assistance from the Cal/OSHA Consultation Service without the concern of receiving an inspection or citations. You can request assistance by telephone, come into one of the offices around the state, or have a consultant come to your worksite.

Resources for information and assistance

Up-to-date information is key to keeping up with the requirements of Section 5193:

- At the Cal/OSHA website you can access a regulatory update which links to the new regulation: **www.dir.ca.gov/dosh**
- At the California Department of Health Services Sharps Program website—www.ohb.org/sharps.htm—you can see a list of needleless systems and sharps devices with e.s.i.p. and their manufacturers, and download a sample Sharps Injury Log.
- The federal OSHA website—www.osha.gov—has links to a wide variety of needlestick prevention resource materials.
- At the CDC website—www.cdc.gov—you can subscribe to Morbidity and Mortality Weekly Report by e-mail, and automatically receive recommendations of CDC, including for post-exposure procedures that are referenced by subsection (f) of Section 5193.
- The International Health Care Worker Safety Center (EPINet) website—www.med.virginia.edu/medcntr/centers/epinet/—has a wealth of information and resources, including a list of needleless systems and sharps devices with e.s.i.p., as well as detailed aggregate data on needlestick injuries recorded by the 70 institutions cooperating in its reporting network.
- The TDICT website—www.tdict.org—contains safety feature evaluation forms and other information to help with the process of evaluating and selecting safer devices.
- The Medical Waste Management Program in the California Department of Health Services has information on California requirements for management of medical waste. You can phone them at 916-327-6904.

State of California—Health and Human Services Agency

California Department of Public Health

Registered Medical Waste Transfer Stations and Treatment Facilities

List Publication Date: December 24, 2024

Revised List - Only Latest Version Is Valid

Medical Waste Management Program Home Page

Medical Waste Transfer Stations (TS)

ID	Company	Address	City	Zip Code	Facility Type	Contact	Phone
TS-32	Advanced Chemical Transport, Inc.	967 Mabury Rd	San Jose	95133	Transfer Only	Jessica Drake	408-548-5050
TS-43	Advanced Chemical Transport, Inc.	600 Iowa St	Redlands	92373	Transfer Only	Keith Munnerlyn	909-406-4400
TS-100	Advanced Chemical Transport, Inc. DBA ACTenviro – Merced	265 Riggs Ave	Merced	95341	Transfer Only	Henry DeSousa	209-722-4228
TS-169	Advanced Chemical Transport, Inc., DBA ACTenviro	12235 Los Nietos Rd	Santa Fe Springs	90670	Transfer Only	Jeff Ruhl	714-545-2191
TS-170	Advanced Chemical Transport, Inc., DBA ACTenviro – Sacramento	4 Wayne Court, Building 9	Sacramento	95829	Transfer Only	Richard Williams	916-299-4228
TS-130	All Clean Hazardous Waste Removal, Inc.	21 Great Oaks Blvd	San Jose	95119	Transfer Only	Pat Johnson	408-363-3678
TS-132	American Textile Maintenance dba Medico Professional Linen	2626 Compton Ave	Los Angeles	90011	Transfer Only	Bruce Moskowitz	323-731-3132

ID	Company	Address	City	Zip Code	Facility Type	Contact	Phone
TS-99	ATI	28358 Constellation Rd, #640	Valencia	91355	Transfer Only	Adam Poladyan	818-787-0037
TS-120	Barnett Medical Services, Inc.	3028 Industrial Way, Unit T	Benicia	94510	Transfer Only	Brett Espicha	510-429-9911
TS-126	Bio Waste Resources	2237 Third St	Eureka	95501	Transfer Only	Jeff Clark	707-445-0500
TS-110	Biomedical Waste Disposal, Inc.	13418 Wyandotte St.	N. Hollywood	91605	Transfer Only	Alik Ghazaryan	818-446-2334
TS-133	Biomedical Waste Disposal, Inc.	116 Heron Way, Ste F	Merced	95341	Transfer Only	Alik Ghazaryan	877-644-2424
TS-149	Clean Harbors Environmental Services	880 Verdulera St	Camarillo	93010	Transfer Only	Jennifer McLaughlin	805-914-1472
TS-172	Clean Harbors Environmental Services, Inc.	6920 Sycamore Canyon Blvd	Riverside	92507	Transfer Only	Sam Barket	323-303-7927
TS-141	Clean Harbors Environmental Services, Inc.	1745 Cebrian St	West Sacramento	95691	Transfer Only	Kevin Davis	916-712-4593
TS-150	Clean Harbors Environmental Services, Inc.	6485 Marindustry Dr	San Diego	92121	Transfer Only	Jacinto Benitez	858-766-7150
TS-164	Clean Harbors San Jose, LLC	660 Lenfest Road	San Jose	95133	Transfer Only	Jeff Reich	408-206-8916
TS-51	Clean Harbors San Jose, LLC	1021 Berryessa Rd	San Jose	95133	Transfer Only	William Bluhm	408-441-0962
TS-72	Clean Harbors Wilmington, LLC	1737 E Denni St	Wilmington	90744	Transfer Only	Michael Gilham	310-835-9998
TS-125	Daniels Sharpsmart, Inc.	3670 Enterprise Ave	Hayward	94545	Transfer Only	Russell Daniels	559-573-6095
TS-119	Eco Medical Inc.	3650 Hess Rd	Red Bluff	96080	Transfer Only	Corey Fitze	707-498-7955
TS-121	Eco Medical Inc.	1749 Alamer Way	Fortuna	95540	Transfer Only	Corey Fitze	707-832-5080
TS-3	Efficient X-Ray, Inc.	9650 Topanga Canyon Place, Suite F	Chatsworth	91311	Transfer Only	Timothy Gray	818-882-8897
TS-74	Emergency Response Medical Waste Disposal	220 Kruse Ave	Monrovia	91016	Transfer Only	Ben Mihm	626-305-9000

ID	Company	Address	City	Zip Code	Facility Type	Contact	Phone
TS-113	Environmental Logistics, Inc.	3200 Depot Rd	Hayward	94545	Transfer Only	Chris Whitt	510-670-9901
TS-156	GAIACA Waste Revitalization DTLA	2016 Bay St	Los Angeles	90021	Transfer Only	Jose Galindo	323-678-4242
TS-29	Haz-Med, Inc.	1607 Los Angeles Ave #H	Ventura	93004	Transfer Only	Roberta Muntzel	805-207-8419
TS-137	Ingenium Group, LLC - Escondido	955 W Mission Ave	Escondido	92025	Transfer Only	Gigi Bealkowski	760-745-8780
TS-139	Ingenium Group, LLC – Sacramento	6063 Foodlink St	Sacramento	95828	Transfer Only	Gigi Bealkowski	916-668-6798
TS-165	Ingenium Group, LLC - Santa Clara	480 Aldo Ave	Santa Clara	95054	Transfer Only	Gigi Bealkowski	408-859-3232
TS-6	Koefran Industries	11350 Kiefer Blvd	Sacramento	95830	Transfer Only	Stan Lawlor	916-361-0911
TS-31	Medical Biowaste Solutions, Inc.	25971 Pala Ste 101	Mission Viejo	92691	Transfer Only	Diana Vizcarra	949-452-0794
TS-129	Medical Environmental Technologies, LLC	7250 Bandini Blvd, Unit 111	Commerce	90040	Transfer Only	Scott McLaughlin	619-448-2000
TS-134	MediWaste Disposal	23575 Cabot Blvd, Suites 215/216	Hayward	94545	Transfer Only	Nick Magdesian	855-449-6334
TS-122	MedWaste Management	2209 American Ave, Unit #6	Hayward	94545	Transfer Only	Frank Rodriguez	866-254-5105
TS-131	MedWaste Management	11420 S Alameda St, #3	Lynwood	90262	Transfer Only	Samuel Hernandez	323-972-8797
TS-171	Med-Waste Systems, LLC	4884 McGrath St, Suite 320	Ventura	93003	Transfer Only	Tiffany Bradley	818-998-5533
TS-167	Med-Waste Systems, LLC	4079 Cherokee Road	Stockton	95215	Transfer Only	Tiffany Bradley	818-998-5534
TS-97	Monterey Sanitary Supply Inc. dba Altius Medical	1 Justin Court	Monterey	93940	Transfer Only	Josh Dalhamer	831-656-9101
TS-36	Patterson Dental Supply	13208 Estrella Ave, Suite F	Gardena	90248	Transfer Only	Stephanie Scotti	310-426-3105
TS-39	PESCO	5451 Warehouse Way, NO. 104	Sacramento	95813	Transfer Only	Jacqueline Luthringer	916-971-9056
TS-5	PRIMA Waste Management, Inc	12401 Woodruff Ave, Ste 10	Downey	90241	Transfer Only	Fernando Vasquez	562-246-1250

ID	Company	Address	City	Zip Code	Facility Type	Contact	Phone
TS-148	Safety-Kleen of California, Inc.	16604 San Pedro St	Carson	90746	Transfer Only	Sam Barket	323-303-7927
TS-160	Safety-Kleen of California, Inc.	4139 North Valentine Ave	Fresno	93732	Transfer Only	Michael Lozier	559-246-1635
TS-10	SSO Medical Waste Management	8101 Monroe Ave	Stanton	90680	Transfer Only	Jeff Katcherian	949-887-5340
TS-11	SSO Medical Waste Management	4263 Birch St	Newport Beach	92660	Transfer Only	Jeff Katcherian	949-756-9090
TS-22	Stericycle, Inc	4135 W Swift Dr	Fresno	93722	Transfer Only	Dave Williams	559-275-0992
TS-104	Stericycle, Inc.	3838 Hill Rd	Lakeport	95453	Transfer Only	Marco Borja	530-755-0585
TS-114	Stericycle, Inc.	30542 San Antonio St	Hayward	94544	Transfer Only	Fernando Campos	510-914-0973
TS-162	Stericycle, Inc.	12316 World Trade Dr. Ste 100	San Diego	92128	Transfer Only	Ricardo Gonzalez	323-828-0054
TS-23	Stericycle, Inc.	11875 White Rock Rd	Rancho Cordova	95742	Transfer Only	Jaron Henderson	916-213-2223
TS-54	Stericycle, Inc.	15610 Boyle Ave	Fontana	92337	Transfer Only	Ruben Ruiz, Jr.	858-229-1860
TS-65	Stericycle, Inc.	4900 Mountain Lakes Blvd B	Redding	96003	Transfer Only	Darren Puett	510-418-2514
TS-138	Trilogy MedWaste West LLC	1024 Industrial Way, Suite H	Lodi	95240	Transfer Only	Pang Hang	559-237-1800
TS-158	Trilogy MedWaste West – Escondido	1996 Don Lee Place, Suite C	Escondido	92029	Transfer Only	Dennis Macfaden	760-519-9057
TS-41	Veolia ES Technical Solutions, L.L.C.	3797 Spinnaker Court	Fremont	94538	Transfer Only	Joshua Sytsma	626-334-5118
TS-44	Veolia ES Technical Solutions, L.L.C.	107 S Motor Ave	Azusa	91702	Transfer Only	Joshua Sytsma	626-334-5117
TS-69	Veolia ES Technical Solutions, L.L.C.	9530 Candida St	San Diego	92126	Transfer Only	Joshua Sytsma	626-334-5119
TS-152	Waste Abatement Resources	40 Executive Court	Napa	94558	Transfer Only	Dan Harberts	707-255-3456
TS-68	WCM Waste & Compliance	6054 Corte Del Cedro	Carlsbad	92011	Transfer Only	Jim Panigall	760-930-9101

ID	Company	Address	City	Zip Code	Facility Type	Contact	Phone
TSOST-66	ACT Medical	2010 Mission Rd	Escondido	92028	**Sanitec** (Red Bag, Sharps, Pathology)	Jeff Ruhl	760-489-5600
TSOST-107	Barnett Medical Services	112 Spenker Ave	Modesto	95354	**Autoclave**	Brett Espicha	925-321-5938
TSOST-127	BioLogic Env. Services & Waste Solutions	23490 Connecticut St	Hayward	94545	**Autoclave**	Alberto Chavez	510-265-1900
TSOST-55	Daniels Sharpsmart, Inc.	4144 E Therese Ave	Fresno	93725	**Autoclave**	Russell Daniel	559-573-6095
TSOST-89	Healthwise Services	4800 E. Lincoln Ave	Fowler	93625	**Autoclave & Sanitec** (Red Bag, Sharps, Pathology)	Mike Mohoff	559-834-3333
TSOST-85	Medical Environmental Technologies	1463 Fayette St	El Cajon	92020	**Autoclave**	Rob Trabucco	619-448-2000
TSOST-9	Medical Waste Environmental Engineers (MWEE)	702 S Depot Rd	Santa Maria	93458	**Autoclave**	Kimberlee Higa	805-925-6633
TSOST-94	Medical Waste Services	7321 Quimby St	Paramount	90723	**Autoclave & Pyrolysis** (All medical waste types)	Erik Nelson	888-610-1311
TSOST-136	MediWaste Disposal, LLC	235 Deininger Cir	Corona	92878	**Autoclave**	Ryan Oganesian	855-449-6334
TSOST-151	Safety-Kleen Systems, Inc.	2170 South Yale St	Santa Ana	92704	**Autoclave**	Jamie Moreno	714-429-4300
TSOST-83	Stericycle, Inc	1551 Shelton Dr	Hollister	95023	**Autoclave**	Joel Ochoa	510-914-0973
TSOST-154	Stericycle, Inc	7873 RA Bridgeford St	Stockton	95206	**Autoclave**	Joel Ochoa	209-291-7114
TSOST-26	Stericycle, Inc	2775 East 26th St	Vernon	90023	**Autoclave**	Jerry Jordan	323-362-3000
TSOST-102	Trilogy MedWaste West LLC - Fresno	3187 E Commerce Ave	Fresno	93725	**Autoclave**	Pang Hang	559-237-1800
TSOST-159	Trilogy MedWaste West - Vernon #707	4280 Bandini Blvd	Vernon	90058	**Autoclave**	Dennis Macfaden	760-519-9057
TSOST-27	Veolia ES Technical Solutions L.L.C	241 W Laurel St.	Colton	92324	**Autoclave**	Joshua Sytsma	626-485-2467
End of Worksheet							

SAMPLE

SHARPS INJURY LOG

DATE	TIME	INFORMATION ABOUT THE INJURY	TYPE & BRAND OF DEVICE/ SHARP	DEPARTMENT/ WORK AREA OF EXPOSURE	EXPLANATION OF HOW THE INCIDENT OCCURRED	FOLLOW- UP CARE

SAMPLE

Cleaning / Housekeeping Schedule

Cleaning solution must state that it kills TB, Hepatitis B, and HIV
Must be EPA approved

	Responsible person
All exam tables and counter tops must be cleaned at the end of each workday with _____. (solution)	_____
All exam tables and counter tops will be cleaned after contact with any infectious materials or after a patient has been in isolation with _____. (solution)	_____
All carpeted floors will be vacuumed every day.	_____
All linoleum/tiled floors will be cleaned every day with _____. (solution)	_____
All toilets will be cleaned every day with _____. (solution)	_____
All sinks will be cleaned every day with _____, (solution)	_____
All general dusting will be performed every day.	_____

Use and Care of Autoclaves

PURPOSE: To ensure sterility of instruments and proper functioning of the autoclave.

POLICY: Autoclave will be cleaned and maintained properly.

PROCEDURE:

1. Autoclaves will be cleaned a minimum of once per month or more frequently based on manufacturer's recommendations.

2. The utilization and maintenance will be based on the specific manufacturer's recommendations: Refer to specific product instructions for utilization and cleaning of autoclave.

3. Autoclave is to be calibrated annually. Dated sticker to be applied.

4. Document the cleaning on the Autoclave Log. See attachments A or B.

SAMPLE

Autoclaving Instruments in Peel Pack Pouches

PURPOSE: To provide guidelines for packaging and maintaining instruments in peel pack pouches.

POLICY: All autoclaved instruments will be packaged and maintained appropriately.

PROCEDURE:

1. Thoroughly clean, rinse, and dry all instruments. Each instrument is inspected carefully for the presence of dried blood or other debris.
2. Place instruments in the autoclave pouch; select size per the instrument being packaged. Do not overfill the pouch with instruments or cause stress to the package.
    a. All jointed instruments should be open and/or unlocked and disassembled, if instrument requires assembly.
    b. Place sharp points of scissors toward the plastic side and the handles toward the top of the pack.
    c. Wrap points with gauze to prevent puncturing of the pouch, which can cause contamination of the instrument.
3. Remove as much air as possible before sealing the pouch, as air acts as a barrier to heat and moisture and may cause rupturing of packages.
4. Whenever moisture is present after the drying and cooling period, the pack must be reprocessed.
5. Label the package with the date of sterilization, load run identification information, and general contents (e.g. suture set). Each item in a sterile package need not be listed on the label if a master list of package contents is available elsewhere on site.
6. When loading packed instruments into the autoclave, arrange peel pack pouches so that materials that are alike are touching (example: Plastic to plastic). This ensures penetration of sterilants, air and/or moisture.
7. Process as prescribed per operational instructions for specific autoclave type.
8. After removal of packs from autoclave, place with plastic side down until packs are cool.
9. Sterilized articles should be carefully handled and stored in a manner that minimizes stress and pressure. Storage for sterilized packages must be clean, dry and separated from non-sterile items by a functional barrier (e.g., shelf, cabinet door, drawer).
10. All sterilized packages will be inspected routinely for damage. In addition, the integrity of the package will always be checked prior to use. Maintenance of sterility is event related, not time related. Sterilized items are considered sterile until used, unless an event causes contamination. However, sterilized items are not considered sterile if the package is opened, wet/moist, discolored or damaged. If any of these conditions exist, the items in the package will be removed from the sterile package storage area and then re-autoclaved.
11. Spore testing will be done at least monthly unless otherwise stated in manufacturer's guidelines, which are kept on site. Spore testing will be done to determine the efficacy of the sterilizing process by either Attest biological testing in office or contracting a laboratory to do spore testing.

Reference:

AORN – Standards and Recommended Practices for Perioperative Nursing, 1993

SAMPLE

AUTOCLAVE LOG

DATE	CLEANING	TIME	TEMP	PRESSURE	LOAD #	CONTENTS	OPERATOR	COMMENTS
	▯ Weekly ▯ Monthly	▯ Full cycle ▯ Other	▯ 270°F ▯ ______	▯ 30 lbs ▯________				▯ None ▯ ____________
	▯ Weekly ▯ Monthly	▯ Full cycle ▯ Other	▯ 270°F ▯ ______	▯ 30 lbs ▯________				▯ None ▯ ____________
	▯ Weekly ▯ Monthly	▯ Full cycle ▯ Other	▯ 270°F ▯ ______	▯ 30 lbs ▯________				▯ None ▯ ____________
	▯ Weekly ▯ Monthly	▯ Full cycle ▯ Other	▯ 270°F ▯ ______	▯ 30 lbs ▯________				▯ None ▯ ____________
	▯ Weekly ▯ Monthly	▯ Full cycle ▯ Other	▯ 270°F ▯ ______	▯ 30 lbs ▯________				▯ None ▯ ____________
	▯ Weekly ▯ Monthly	▯ Full cycle ▯ Other	▯ 270°F ▯ ______	▯ 30 lbs ▯________				▯ None ▯ ____________
	▯ Weekly ▯ Monthly	▯ Full cycle ▯ Other	▯ 270°F ▯ ______	▯ 30 lbs ▯________				▯ None ▯ ____________
	▯ Weekly ▯ Monthly	▯ Full cycle ▯ Other	▯ 270°F ▯ ______	▯ 30 lbs ▯________				▯ None ▯ ____________
	▯ Weekly ▯ Monthly	▯ Full cycle ▯ Other	▯ 270°F ▯ ______	▯ 30 lbs ▯________				▯ None ▯ ____________
	▯ Weekly ▯ Monthly	▯ Full cycle ▯ Other	▯ 270°F ▯ ______	▯ 30 lbs ▯________				▯ None ▯ ____________
	▯ Weekly ▯ Monthly	▯ Full cycle ▯ Other	▯ 270°F ▯ ______	▯ 30 lbs ▯________				▯ None ▯ ____________
	▯ Weekly ▯ Monthly	▯ Full cycle ▯ Other	▯ 270°F ▯ ______	▯ 30 lbs ▯________				▯ None ▯ ____________
	▯ Weekly ▯ Monthly	▯ Full cycle ▯ Other	▯ 270°F ▯ ______	▯ 30 lbs ▯________				▯ None ▯ ____________
	▯ Weekly ▯ Monthly	▯ Full cycle ▯ Other	▯ 270°F ▯ ______	▯ 30 lbs ▯________				▯ None ▯ ____________
	▯ Weekly ▯ Monthly	▯ Full cycle ▯ Other	▯ 270°F ▯ ______	▯ 30 lbs ▯________				▯ None ▯ ____________

SAMPLE

Chemical Disinfection

PURPOSE: To provide guidelines for disinfection of instrumentation and durable equipment.

POLICY: The recommended guidelines for disinfection of instrumentation and durable equipment will be followed.

PROCEDURE:

1. The selection and use of chemical disinfectants.
    a. Critical items (items that enter sterile tissue of the vascular system) shall be sterile.
        1) Endoscopes and other endoscopic equipment that enter body cavities are classified as critical items and shall be subject to a sterilization process. If this is not possible, they shall receive at least high-level disinfection.
    b. Semi-critical items (items that encounter mucous membranes of non-intact skin) shall receive high-level disinfection.
    c. Basic cleaning may be sufficient for non-critical items (items that come in contact only with intact skin) and shall receive intermediate to low level disinfection.
2. Items shall be thoroughly cleaned before disinfection.
    a. In accordance to manufacturer's written instructions, medical devices with multiple pieces shall be disassembled for cleaning.
    b. Enzymatic detergents may be used to facilitate the cleaning process.
    c. Following the cleaning process, instruments shall be thoroughly rinsed and dried before the disinfection process.
3. Chemical disinfectants shall be used per the Association of Practitioners in Infection Control (APIC) recommended guidelines.
    a. All chemical disinfectants used in the practice setting shall be registered with the Environmental Protection Agency (EPA) and approved for use by the Food and Drug Administration (FDA).
    b. Manufacturer's written instructions shall be followed when preparing solutions and calculating expiration dates.
    c. The efficacy of the chemical disinfectant shall be checked and documented once in each 24-hour period of normal operating hours.
    d. Items shall be completely immersed in the chemical disinfectant.
        1) Lumens shall be completely immersed in the chemical disinfectant.
    e. Items shall remain immersed for the entire recommended exposure time.
    f. Critical and semi-critical items shall be thoroughly rinsed by immersing them manually in three (3) separate volumes of sterile water, or a continuous rinse with an automated system.
        1) Lumens shall be flushed with sterile water during each of the three (3) separate manual rinses.
4. The practice setting shall provide a safe environment for personnel when using chemical disinfectants.
    a. Chemical disinfectants shall be kept in a covered container.
    b. Chemical disinfectants shall be kept in well-ventilated areas.
    c. Protective apparel, including eyewear and gloves shall be worn when using chemical disinfectants.
    1) Additional protective apparel shall be worn dependent on risk.

d. Disposal of chemical disinfectants shall adhere to Federal, State, and Local regulations.

SAMPLE

Spore Testing

PURPOSE: To provide guidelines for monitoring autoclaves for the lethality of steam sterilization process, to insure product sterility.

POLICY: Spore testing to be completed once a month or per manufacturer's guidelines. Results to be kept with autoclave log.

PROCEDURE:

1. Obtain ampules from contracted laboratory.

2. Follow manufacturer's direction for intended use.

3. Return ampules to laboratory for examination and ultimate results.

4. **If results are positive**, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs. All instruments autoclaved since the last negative spore test must also be removed to avoid use of a possibly un-sterilized instrument. Follow the "5 R" procedure which is as follows:

   Report
   Repair
   Retrieve
   Retest
   Re-sterilize

SAMPLE

Policy and Procedure: Appropriate handling and transport of contaminated equipment and/or instruments

Purpose: To prepare contaminated instruments for transport:

1. All individuals with potential contact with the instruments have been given the required Blood Borne Pathogens training.

2. The instruments are sprayed with an enzymatic foam. Point-of-use cleaning is required to remove blood/body fluids prior to transport.

3. The contaminated instruments are placed into a puncture resistant, plastic container with a lid that is marked with an approved biohazard label.

4. The container is then transported to _____ for processing.