

Sample Office Policies and Procedures

INTRODUCTION

These sample office policies and procedures are provided to your office from Physicians Medical Group of San Jose, Inc. Many of these policies and procedures are required by our contracted payors (Commercial, Medicare, and Medi-Cal HMO's) and are offered as templates to assist you with your office policy and procedure development. We strongly encourage you to review, modify, and implement them. PMG will continue to review your policies during routine site and medical records review.

Please feel free to contact the Provider Services Department at (408)937-3612 or (408) 937-3604 with any questions.

Thank you.

Provider Services

Disclaimer:

These policies are provided as samples only. Review and modify as needed for your office.

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1. MEDICAL OFFICE FACILITY STANDARDS

Policy

- The medical office will be clearly identified on the exterior of the building. The office will be identified near the street entrance and at the front door entrance.
- Facilities must be accessible to the physically disabled. Parking, elevators, ramps, hallways, waiting rooms, examining rooms, and restrooms will be clean and clear of debris.
- Facilities must be readily accessible to the mentally disabled.
- A plan showing exits for evacuation during an emergency must be posted where it can be easily seen.
- Office hours will be clearly posted.
- Provide at least two examination rooms per physician on duty.
- Make fire extinguisher(s) visible and conveniently located. Have the extinguishers tagged and inspected annually.
- Keep hallways, doorways, and exists free of any obstruction.
- Keep trash contained and properly stored.
- Do not store prescription pads, needles, or syringes in examination rooms or within patient's access.
- On-site lab is CLIA certified, or if meets requirements has a certificate of waiver.

2. EMERGENCY PLAN PROCEDURES

Note to User: The sample policy below includes an underlined item for you to select or enter.

General Emergency Plans, Disaster, and Safety Procedures

All staff members are trained on the following procedures. In case of an office emergency or disaster, staff members will immediately:

1. Assess the type and extent of emergency, if possible.
2. Assure that all staff, patients, and visitors are evacuated to a safe place using emergency exits.
3. Assure personal safety.
4. Call (911/other number) and report disaster

EMERGENCY PLANS: Evacuation

Policy

All employees shall be familiar with the disaster plans to assist in a safe evacuation of the building.

Procedure

1. An evacuation plan is required to be posted and accessible to patients and employees.
2. In the event of evacuation, all employees, including physicians, are required to assist in the safe evacuation of patients.
3. Exit signs are clearly posted.
4. Employees shall become familiar with the emergency exits and exit plan.
5. Evacuation of ambulatory patients.
 - Patients, staff, and any other individuals shall be directed to evacuate away from the danger area.
 - **Do not use elevators.**
 - Back office staff shall be responsible for supervising the evacuation of the exam rooms.
 - Front office staff shall be responsible for supervising the evacuation of the reception area.
 - Individuals should be calmly instructed to collect their belongings and follow you to the nearest exit.
6. The Office Lead shall act as the designated person to instruct all employees during the evacuation and of the steps necessary once the evacuation has been completed. All employees should locate the Office Lead for their office/suite for further instructions. The Office Lead will take count of employees to ensure that everyone has evacuated safely. In buildings where one or more offices are occupied by the company, each Office Lead shall be responsible for their individual suite.
7. When deemed safe, the Office Lead shall instruct employees in pairs to re-enter the building to perform the following tasks:

EMERGENCY PLANS: Evacuation (cont'd)

- Unplug all machinery and lock all cabinets containing medication;
 - Turn off gas, water and electricity to the building;
 - Survey the damage and look for any individuals who may not have evacuated;
 - Retrieve the emergency drug box to provide emergency care for any individuals in need.
8. The Office Lead shall designate a person to call the Practice Management Director or Operations Manager.
 9. No front office or back office staff shall leave the parking area unless instructed to do so by the Office Lead, Practice Management Director or Operations Manager.
 10. All physicians are required to remain in the parking lot until dismissed by the Practice Management Director or Operations Manager.

EMERGENCY PLANS: Earthquake

Policy

All employees shall be familiar with the disaster plans to assist in the event of an earthquake, and to inform employees of the proper safety procedures in the event of an earthquake.

Procedure

1. Remain calm at all times. Reassure others to remain calm.
2. Immediately instruct patients and any other individuals in the room to find protection under something structurally sound (desk, sturdy fixture) or braced in a doorway. If unable to locate a safe place, use items such as cushions, mattresses, or chairs for protection. Remain in that location/position until the earthquake/shaking is over.
3. Staff and patients should not leave the building during the earthquake.
4. Stay away from windows.
5. If the earthquake appears to be minor (no damage noted, and all systems still functioning) continue working.
6. If the earthquake appears to be major (damage noted and systems are not operational) evacuate the building through the main entrance into the parking lot in accordance with the evacuation policy.
7. In the event that a patient or employee is injured and is not trapped, do not attempt to move the individual alone. Call for assistance from another adult.
8. In the event that a patient or employee is injured and is trapped, do not attempt to move the individual if the earthquake is still shaking. Wait for the earthquake to end. Call for assistance from another adult. Any attempts made to free the individual should not increase risk to others.
9. If a trapped individual is unable to be freed, immediately evacuate the building and notify emergency services (911). Stay outside the building until the emergency personnel have arrived to assist in locating the trapped individual.

10. Do not re-enter a damaged building unless instructed to do by emergency personnel.

Note: Earthquakes are usually followed by a series of smaller, yet potentially dangerous aftershocks. Continue to follow the procedures above to prevent possible injury.

EMERGENCY PLANS: Fire

Policy

All employees shall be familiar with the disaster plans to assist in a safe evacuation in the event of a fire.

Procedure

1. If a fire occurs in your area, quickly evacuate all individuals who are in immediate danger. All office exits are to be marked and illuminated. Building exits are also to be marked and illuminated.
2. Keep all corridors clear of any equipment, supplies, or debris.
3. Fire exits should not be obstructed or blocked at any time.
4. Close the door to prevent the fire from spreading.
5. If the fire is minor, use the fire extinguisher to put it out. Minor fires are defined as fires that are localized to a small corner or table, and do not present an immediate danger of spreading. The fire extinguisher can be used to put out fires associated with paper, drapes, computer equipment, wiring, wood, oil, paint, gasoline, and solvents. Do not attempt to extinguish a fire that is moving and/or growing.
6. Once the fire is successfully extinguished, the Office Lead shall contact the Fire Department to notify them of the incident.
7. If the fire is moving or spreading rapidly, the person finding the fire shall be responsible for assigning an individual to notify the staff of the fire and to call the Fire Department
8. All individuals shall evacuate the building through the main entrance into the parking lot in accordance with the evacuation policy. Employees shall assist any non-ambulatory or elderly patients upon evacuation. **Do not use the elevators for evacuation.** Non-ambulatory or elderly patients should be assisted in the stairwell by employees.
9. Upon evacuation, the front desk staff shall position themselves outside of all entrances into the building to prevent anyone from entering.

10. The Office Lead shall take a formal count of all personnel to determine if all employees have evacuated.

11. **Do not re-enter the building under any circumstances.**

Prevention Reminders:

- Electrical cords and plugs should be routinely checked for fraying.
- Turn off all electrical equipment before leaving for the day, i.e., the coffeepot.

FIRE SAFETY POLICY

Note to User: The sample policy below includes blank items for you to fill in reflecting the items that are relevant to the practice.

The fire safety policy of this office is, in every event of fire or disaster, act in a manner to preserve lives, prevent panic and the spread of fire. All employees must be aware of and receive training regarding:

- Proper fire safety procedures
- Fire exits
- Fire extinguishers (and sprinkler system)
- Fire zones and applicable space requirements
- Staff member requirements and responsibilities
- Steps to take in the event of fire
- Containment of fire and smoke

Staff is not expected to take any actions that may endanger his or her life, but to ensure the safety of patients and staff the office maintains these requirements:

1. All employees will participate in an annual fire extinguisher training class. A record of individual training is to be maintained in _____.
2. Fire drills are conducted by building management at least every _____. Both morning and afternoon shifts will participate in fire drills to ensure:
 - a. Sufficient exposure to procedures for responding to fire, including office and building exits.
 - b. Practice to avoid panic under emergency circumstances.
 - c. Fire safety education training.
3. The office conducts or arranges for appropriate in-service of office personnel on fire safety and prevention topics.

Note to User: The sample procedures description includes a blank for the number of the fire department or emergency call center.

The steps listed below are followed as quickly as possible in the event there is any uncontrolled flame or smoke in or near the office/building or its perimeter:

1. Alert all people in the office of fire threat and evaluate fire and extent of flames and smoke.
2. Evacuate patients and visitors from the immediate area.
3. Activate fire alarm.
4. Report fire to the fire department. **Dial _____**. Notify fire department of location of fire, extent of fire/flames/smoke, type or cause of fire, if known.
5. If possible, confine the fire by closing all doors and windows. If there is time, turn off electricity
6. If possible, extinguish fire using fire extinguisher(s).
7. Determine safe area for meeting fire department; designate individual to meet, or directly meet with fire department personnel.
8. After office is secured and fire department personnel authorize entry to the office, reset fire alarm and arrange for fire extinguisher refills, reinstallation.

Fire Extinguishers/Sprinkler System Policy

Note to User: The sample policy below includes underlined items for you to select when tailoring your own policy to the practice.

The office/building maintains fire extinguishers / a sprinkler system to use in case of fire. All extinguishers are inspected on a routine basis to assure good working condition. The office conducts or arranges for an annual training session regarding the location and use of fire extinguishers.

FIRE PREVENTION PROCEDURE

Policy

The office maintains and trains all employees on basic office fire prevention procedures, including:

- All office exits are marked and illuminated. Building exits are also marked and illuminated.
- All corridors are kept clear from equipment and supplies.
- Fire exits are not obstructed or blocked at any time.
- Electric cords and plugs are routinely checked for fraying.
- All machines in the staff lounge are turned off at the end of the day i.e., the coffee machine.

EMERGENCY PLANS: Power Outage

Policy

All employees will be familiar with the disaster plans to assist in the event of a power outage.

Inform employees of the proper safety procedures in case of a power outage.

Procedures

1. In the event that the building loses power for more than five minutes, the Office Lead and/or Switchboard Operator shall check the circuit breaker.
2. If the power is restored by tripping the breaker, the Office Lead shall record the time and date of the power outage, as well as any additional action that was needed in restoring power. Patient care should continue as scheduled unless otherwise informed by the Office Lead.
3. If the power is not restored by tripping the breaker, the Office Lead and/or Switchboard Operator shall notify all employees to continue patient care as regularly as possible. Patients shall be instructed to safely leave the building via the stairway, if able.
4. The Switchboard Operator shall call PG&E (Pacific Gas and Electric) to determine the possible cause and length of the power outage. In the event that PG&E is unaware of the power outage, the office doors should be locked and a sign requesting patients knock for assistance.

EMERGENCY PLANS: Bomb Threat

Policy

All employees shall become familiar with the disaster plans to assist in the event of a bomb threat. To inform employees of the proper safety procedures in the event of a bomb threat, do the following:

Procedure

1. When a threatening phone call has been received, it should be documented in detail, including the time received and gender of the caller. Be attentive to any distinguishing background noises or characteristics of the caller's voice. Take note of the phone line the call came in on.
2. The Police Department should be notified immediately by the Office Lead.
3. The Office Lead shall inform the staff of the threat and ask each person to search their area for suspicious looking objects. Other areas such as restrooms, utility closets, and stairwells should be searched by an employee designated by the Office Lead.
4. If a suspicious object is discovered, the area should be sealed off and the Office Lead notified.
5. All steps should be taken to continue with regularly scheduled patient care, unless instructed differently by the Office Lead or Law Enforcement.
6. If determined unsafe by the Office Lead (in conjunction with the Police Department) the building shall be evacuated through the main entrance into the parking lot in accordance with the evacuation plan.

3. OFFICE PROCEDURES: Appointment Status Change

Policy

Document changes in a patient's appointment status.

Procedure

1. The receptionist will be responsible for notifying the nurse or provider regarding the change in a patient's appointment.
2. The designated employee will document, in the patient's chart, the change in appointment status as follows:
 - "No Show" – patient does not arrive for scheduled appointment.
 - "Cancelled" – patient cancels appointment on the date of the scheduled appointment (include a reason if known).
3. "Rescheduled" – patient or provider changes the date of appointment (include a reason if known).
4. "Cancelled >24 hours" – patient cancels appointment more than 24 hours before appointment but does not reschedule.
5. The provider shall be notified of the patient's appointment change to allow the provider to determine if the visit is medically necessary. This will determine the need for aggressive follow-up.
6. There must be two attempts to contact the patient on the telephone to reschedule and at least one attempt in writing.
 - The emergency contact number should be utilized to contact the patient if necessary.
 - If the visit is for a medical-legal condition, the letter should be sent certified, return receipt requested.

OFFICE PROCEDURES: Appointment Status Change, No Show Policy

Policy

Office hours are to be posted on the front door and reviewed with patients during their office visit. All patients will have access to a physician on-call 24 hours a day or, in emergency situations, referred to the nearest emergency room.

Procedures

1. Effective patient scheduling is essential for of patients to have access to clinical care, to ensuring office productivity, and supporting client rights.
2. Careful management of patient's access to the office is critical for quality and patient satisfaction.
3. Whenever possible, patient convenience and appointment preference should be accommodated.
4. While appointment scheduling should follow guidelines established by the practice, there should be flexibility to support treating physicians' decisions regarding a patient's access to clinical services, appointments, and patient flow management.
5. Surveys are made from time to time to see if there is a written policy or guidelines statement regarding appointment scheduling, and if the guidelines are followed in actual practice. The surveyors will also inquire regarding the practice's systems for handling missed and cancelled appointments, and check for follow-up attempts in the medical records, where appropriate.
6. The template provided on the following page requires the user's input and customization to the particular practice.

OFFICE PROCEDURES: Appointment Scheduling Guidelines

The office maintains patient appointments based on patient clinical need, patient preference, clinical staff availability, and time requirements for the type of appointment. Office appointments should follow the guidelines shown below:

Type of Appointment/Definition	Guideline for Scheduling Appointment
Annual Health Physical Examination. Comprehensive annual examination and physical appropriate for age and gender of patient.	Available within < > days. Annual physicals require a < > minute appointment.
Routine Care. Patients visit for routine preventive care other than a comprehensive physical examination.	Available within < > days. Routine appointments require a < > minute appointment.
Non-Urgent Examination. Conditions requiring clinical examination for patient complaints, signs and symptoms of illness, with no immediate threat to the patient.	Available within < > days, depending on patient circumstance.
Urgent Examination. Conditions requiring medical intervention on the same day.	Available within the same day or Available within < > hours.
Emergency Care/Situation. Life-threatening or other conditions for which the patient needs to be seen immediately	Available immediately, or referred to nearest emergency room.

Missed/cancelled appointments Policy

Missed (no shows or extremely late patients) and cancelled appointments will be tracked for continuity of care. The office tracks missed and cancelled appointments in the medical record in the event appointment(s) are not rescheduled by the patient. Depending on the nature of the appointment (e.g., post-operative care or essential treatment follow-up), office staff may attempt to reschedule the appointment. Attempts to reschedule will be documented in the patient's medical record.

Note to User: The sample policy below includes blank items for you to fill in reflecting the actual office hours of the practice.

The office will provide clinical services by appointment ____ hours daily, ____ days a week. Office hours are posted on the front door and reviewed with patients during their office visit. All patients will have access to a physician on-call 24 hours a day, or in emergency situations, referred to the nearest emergency room.

During the week (Monday through Friday), patients needing appointments after hours, are referred to _____.

(Insert name of after-hours physician or practice)

OFFICE PROCEDURES: No Show Policy

Policy

To track patients who fail to appear for their appointment and fail to call.

Procedure

1. A No Show Patient is one who:
 - Cancels their appointment without rescheduling or,
 - Does not appear for their appointment.
2. All No-Shows will have the progress note in their medical record stamped with a “No-Show” stamp by a front office appointment staff person by the end of the business day.
3. All No-Shows will be contacted by phone, letter, or postcard to encourage prompt rescheduling of the appointment.

Note: Under no circumstances shall a patient be penalized for a “no show” if the doctor reschedules their appointment (e.g. emergency, etc.)

OFFICE PROCEDURES: Patient Emergencies/Triage

Policy

To ensure that a patient's needs are met in an emergency situation. Appropriate evaluation and management of patients in emergency situations are dealt with so as to optimize the patient's health and well-being. The medical office personnel will be trained in patient emergency procedures. It is recommended that the practitioner and at least one nurse maintain CPR certification. If emergency equipment is kept, it is also required that the equipment be kept current and complete and assessed/ documented for same on a regular basis.

Procedure

1. When a potential medical emergency is recognized, the physician or nurse is notified by calling for help. Two persons will stay with the patient, if possible.
2. If possible, a 3-4 member team will be formed with one person (usually the practitioner or RN) in charge giving directions.
3. All other staff will continue patient services as usual and maintain a calm attitude.
4. The practitioner or nurse in charge will conduct a physical assessment of the patient and carry out essential medical procedures with the assistance of other designated staff.
5. A medical assistant will move available emergency equipment and supplies to the patient care area.
6. 911 will be called if patient care needs are beyond the scope of the practitioner's office

7. Urgent patient conditions, such as elevated fever or pain should be routed to the physician or nurse. If a clinician speaks to the patient, the clinician should review the patient's record, and through discussion with the patient, assess the patient's condition to determine:

- Need to see the physician and timeframe for the visit.
- Need for medication or adjustment to current medication.
- Immediate recommendations for patient's next steps.
- Severity of the patient's condition.
- Behavior modification, such a limitations on physical activity, etc.
- Time interval for follow-up and next communication.

OFFICE PROCEDURES: Telephone Evaluation, After Hour Telephone Calls

Policy

The telephone is typically the first point of access by the patient to the practice. It is important that all staff, employees and temporary personnel, is aware of how telephone calls are handled during and after office hours.

Procedures

1. The office telephone answering machine is turned on whenever staff does not directly answer calls. Routine times for using the answering machine may include; midday lunch hour, after office hours, and on weekends.
2. The answering machine message informs callers to immediately dial (*phone number*), the number for the clinic on-call group. The answering service has immediate access to the office on-call group/physician.
3. The message/answering service relays normal office hours for access to staff and patient appointments.
4. The message invites callers to leave a message after the tone. Answering service records all caller messages.
5. Physicians and clinical staff, who see patients, are available by pager when on duty but away from the office. Staff will page the physician and leave a text message when appropriate.
8. Telephone calls with medical emergencies, such as; chest pain, anaphylactic shock, heavy bleeding, fainting, etc., are routed to the physician immediately. If no physician is available, the next qualified clinician should instruct the patient to go the emergency room.

OFFICE PROCEDURES: Refusal of Treatment

Policy

To ensure that the patient has been given all the relevant information and has a complete understanding of the procedures being ordered by the provider and is making an informed decision to refuse treatment.

Procedure

1. Whenever a patient refuses drugs, treatment, or other procedures ordered by the provider, the provider will be contacted immediately.
2. The provider will explain (re-explain) to the patient the reasons for requiring the particular drug, treatment or other procedure and the possible ill effects.
3. The provider will provide the patient with all the information that is relevant so the patient is able to understand the consequences of declining to follow the recommended course of action.
4. The provider will note in the patient's medical record the initial refusal and the outcome (e.g., consent given or continued refusal).
 - The note will specifically document that the provider gave the patient the relevant information, including that pertaining to the potential consequences of declining to follow the recommended course of action.
5. Valid consent can only be obtained if the patient is free of duress or coercion.
6. "Refusal to Permit Medical Treatment" forms must be completed.
 - The patient will be asked to read and sign the form. The patient's signature will be witnessed by a responsible employee.
 - If the patient refuses to sign the form, the notation "Patient Refuses to Sign" will be written on the signature line, and the witness will sign the form on the designated line.

A Sample form is on the next page.

REFUSAL TO PERMIT MEDICAL TREATMENT

I hereby acknowledge that my attending physician, _____ has fully informed me of the risks, possible complications, expected benefits, and the alternatives to receiving the following medical treatment:

Notwithstanding the recommendations of my attending physician, I hereby refuse the foregoing treatment for me or my child. I hereby release my provider, his/her personnel, and any other persons participating in my care from any responsibility whatsoever for unfavorable or untoward results which I understand may occur as a result of my refusal to permit this medical treatment.

Patient/Parent/Conservator/Guardian

Date

If signed by other than the patient,
indicate relationship to the patient.

Witness Signature

Date

Original goes into the patient's medical record; one copy goes to the patient for their records.

OFFICE PROCEDURES: Consent Policies

Policy

If a patient lacks the capacity, (the ability to understand the nature and consequences of the proposed treatment), the patient's representative has the right to give informed consent or refusal on the patient's behalf.

Procedure

Patient Consent (with or without representative) and minor

1. The patient's incapacity is to be determined by a court (per Probate Code 810-814) or,
2. Incapacity determination may be made by the patient's physician unless the physician's determination is disputed by the patient or the patient's representative. If incapacity is determined by the physician, that determination and its proponents shall be documented in the patient's medical record.
3. A patient's representative may be – a person designated under the Durable Power of Attorney, a conservator specifically authorized by a court to make health care decisions pursuant to Probate Code 1800 and 3200 *et seq.*, a next of kin, any other appropriate surrogate designated consistent with statutory and case law, or if the patient is a minor, someone lawfully authorized to represent the minor.
4. Informed Consent Forms should include the following:
 - Authorization for a specified physician (and the physician's assistants) to perform a specified medical procedure (described in both medical and lay terms).
 - General description of procedure's risks which may occur in connection with the procedure as well as a list of risks specific to the procedure, and a disclaimer statement regarding inability to list all possible undesirable effects and procedures which may or may not improve patient's condition.
 - Describe alternative methods of treatment, their risks and benefits, and why the physician recommends the specified procedure.
 - Describe anticipated benefits of the specified procedure with a disclaimer regarding guarantees or assurances.
 - Allow and encourage the patient and representative to ask questions concerning the procedure. Answer each question fully.

OFFICE PROCEDURES: Consent Policies (Cont'd)

- Provide space for the patient's name, or legal representative, a place for his/her signature, and the relationship of the representative.
 - State the patient has had an opportunity to obtain a second opinion.
5. Advise the patient that unforeseen circumstances may arise which may make it necessary or advisable, during the course of the procedure, to perform different or additional procedures. The patient must consent, in writing, to the performance of these procedures.
 6. Document if the patient has received and reviewed additional material concerning the procedure, such as pamphlets, audiotapes, videotapes, slide presentations, lectures, etc.
 7. Encourage the patient or representative to ask questions.
 8. **Specific Procedures:** Compliance with California statutes is required in the case of assisted reproduction, blood testing in pregnancy, HIV testing, genetic testing, blood transfusions, breast cancer, treatment of patients with Dimethyl Sulfoxide (DMSO), hysterectomy, prostate cancer, silicone implants/collagen injections, research, sterilization, immunizations, electro-convulsive therapy, psychosurgery, psychotherapeutic drugs and physical restraints, human experimentation, and investigational use of drugs and devices. Some of these are discussed below:
 - **Assisted Reproduction:** Written consent must be received from the patient before a physician removes sperm or ova from a patient that will **not** be reimplanted in the same patient, or implanted in the patient's spouse. The consent must meet the following criteria:
 - Be in writing and contain the statement "I, [name of donor] do hereby donate [type and number, if applicable, of sperm or ova] to [name of clinic or other donee] for [specify purpose];
 - Contain a statement by the donor that provides for the disposition of any unused donated material;
 - Be signed by the patient and the physician who removes the sperm or ova;
 - Contain a notification that this is an important document that should be retained with other vital records.

OFFICE PROCEDURES: Consent Policies (Cont'd)

If the procedure takes place in the hospital, the physician must provide a copy of the consent to the hospital. **A violation of the assisted reproduction consent procedure constitutes unprofessional conduct and may subject to the physician to civil and criminal liability.**

- ***Blood testing in Pregnancy.*** A physician providing prenatal care or attending a woman at the time of delivery must obtain or cause to be obtained a blood specimen on the 1st visit or within 10 days thereafter, and submit it to an approved laboratory to be tested for syphilis. That physician must also obtain a blood specimen for determination of rhesus (Rh) blood type and hepatitis B.
- ***HIV Testing.*** Physicians must offer HIV information and counseling to every pregnant patient.
- ***Genetic Testing.*** Physicians must offer genetic testing to every pregnant woman. Physicians must genetically test each child born in California, unless a parent or guardian of the new born child objects on religious grounds (per Health & Safety Code 125000, 17 C.C.R. 6500 *et seq.* And 6521 *et seq.*)
- ***Blood Transfusions.*** Whenever there is a reasonable possibility that a blood transfusion may be necessary as a result of a medical or surgical procedure, the physician must inform the patient of the benefits and risks of receiving various types of blood transfusion options. The physician must provide the information by means of the standardized written summary (“If You Need Blood”) produced by the State Department of Health Services (DHS). Physicians must obtain and use the most current summary, reviewed by the DHS annually. Copies of the summary may be requested of the DHS by writing to P. O. Box 1015, North Highlands, CA 95660. The physician must note, in the patient’s medical records, that the standardized written summary was given to the patient. When no emergency or contraindication exists, the physician must allow adequate time before the procedure for pre-donation to occur, unless the patient consents to an earlier time. DHS recommends that, in general, the optimal donation period begin 4-6 weeks prior to surgery and the last blood donation be collected no later than 72 hours before surgery.
- ***Breast Cancer.*** Health & Safety Code 109275 requires that physicians provide a standardized summary discussing alternative breast cancer treatments and their risk benefits. In addition, physicians must note in the patient’s chart that the physician has given the patient the summary prior to the performance of a

biopsy. Distribution of a brochure prepared by DHS constitutes compliance with the law. This brochure may be ordered from:

Breast Cancer Treatment Options

1430 Howe Avenue, Suite 50

Sacramento, CA 95825

Phone (916) 263-2466 or Fax (915) 263-2479

- Health & Safety Code 109277 requires every physician who screens or does biopsies for breast cancer to post a sign with prescribed wording relating to the above brochure. The sign concerning the brochure must be posted near where the breast cancer screening or biopsy is performed or at the patient registration area. The sign must be at least 8-1/2" x 11" and conspicuously displayed so as to be readable. The words "Be Informed" must be at least 1/2" in height and centered on a single line with no other text. The message must appear in English, Spanish, and Chinese.
- ***Treatment of patients with a DMSO preparation:*** Special informed consent requirements apply. Before treating a patient with DMSO, the physician must inform the patient, in writing, if DMSO has been approved by the FDA as a treatment or cure for the disorder for which it is being

OFFICE PROCEDURES: Consent Policies (Cont'd)

prescribed. If DMSO is being prescribed for any purpose other than those that have been approved under the statutes governing new drug and device applications, the physician must first obtain a signed and dated written informed consent form from the patient.

- ***Hysterectomies:*** Physicians must obtain verbal and written informed consent before performing a hysterectomy on any patient unless the hysterectomy is performed in a life-threatening emergency (in which case, the physician must hand write and sign a statement certifying the nature of the emergency). The consent must contain the following:
 - That the woman is free to withhold or withdraw consent at any time before the hysterectomy without affecting the right to future care or treatment and without loss or withdrawal of any state or federally funded program benefits to which the individual might be otherwise entitled.
 - A description of the type or types of surgery and other procedures involved in the proposed hysterectomy, and a description of any known available and appropriate alternatives to the hysterectomy.
 - Unless the patient has been sterile previously or is post-menopausal, advice that the hysterectomy procedure is considered to be irreversible, and that infertility will result.
 - A description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used.
 - A description of the benefits or advantages that may be expected as a result of the hysterectomy.
 - The woman's signed written statement prior to the performance of the hysterectomy indicating that she has read and understood the written information provided above, and that this information has been discussed with her by her physician or the physician's designee. Unless the patient has been sterile previously or is post-menopausal, this statement must specifically indicate that the woman has been advised that the hysterectomy will render her permanently sterile and incapable of having children.

OFFICE PROCEDURES: Consent Policies (Cont'd)

- Prostate Cancer.*** Health & Safety Code 109282 requires every physician who screens for or treats prostate cancer to post a sign with prescribed wording. The sign must be posted near to where prostate cancer screening or treatment is performed or at the patient registration area. The sign must be at least 8-1/2" x 11" and conspicuously displayed so as to be readable. Moreover, the words "Be Informed" must be at least 1/2" in height and centered on a single line with no other text. Finally, the message must appear in English, Spanish and Chinese. DHS recommends the use of forms and summaries produced by the National Cancer Institute. These may be obtained by calling them at (800) 4CANCER.
- ***Silicone Implants/Collagen Infections:*** The Cosmetic Implant Act of 1992 (Business and Professions Code 2259 and 2259.5), requires physicians to supply silicone implant patients a standardized written summary describing the risks and possible side effects of silicone implants used in cosmetic, plastic, reconstructive, or similar surgery before the physician performs the surgery. In addition, collagen injection patients must receive similar materials regarding collagen injection. The physician must also note in the patient's chart that the patient was given the standardized written summary or other written information required under these laws. DHS recommends that until DHS summaries are available, physicians should distribute the material prepared by manufacturers since such materials are FDA approved.
 - ***Research.*** A physician is required to inform a patient of the physician's research or other economic interests, and must obtain an informed consent.
 - ***Sterilization.*** For private pay – an adult or a minor, with legal capacity to consent to medical treatment, can consent to sterilization. For Medi-Cal, a patient must be at least 21 in order to consent to sterilization. A person must also be able to understand the content and nature of the informed consent process prescribed in application regulations and is able to give voluntary consent to the sterilization. A competent person may not give informed consent to be sterilized if the person is – in labor or within 24 hours after birth or after an abortion, seeking to obtain or obtaining an abortion, or under the influence of alcohol (ETOH) or other substances that affect the individual's state of awareness. An incompetent person can be sterilized pursuant to a court order under certain circumstances. Sterilization informed consents must be obtained as follows:

- ⇒ The person who obtains the sterilization consent provides the individual with a special consent form and a patient pamphlet on sterilization, both published by the DHS in Spanish and English. The sterilization pamphlets are “Understanding Sterilization “ and “Understanding Vasectomy.” The consent forms are “Medi-Cal/Federally Funded Patients Consent Form” PM 330, and “Consent Form (Non-Federally funded” PM 283. These forms and pamphlets may be requested from DHS at 1037 N. Market Blvd., Suite 9, Sacramento, CA 95834.
- ⇒ The person who obtains the consent must offer to answer any questions the individual to be sterilized may have concerning the procedure.
- ⇒ The person obtaining the consent must orally provide all of the following information:
 - Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled.
 - A full description of available alternative methods of family planning and birth control.
 - Advice that the sterilization procedure is considered to be irreversible.
 - A thorough explanation of the specific sterilization procedure to be performed.
 - A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used.
 - A full description of the benefits and advantages that may be expected as a result of sterilization.
 - Approximate length of hospital stay and time for recovery.
 - Financial cost to patient.
 - Information that the procedure is established or new.
 - Advice that the sterilization will not be performed for at least 30 days, except under certain circumstances.

⇒ Steps are taken to ensure that the patient understands the above information (i.e. determine that information was effectively communicated to a blind, deaf or otherwise disabled patient, an interpreter is provided to the patient so that information is communicated in patient's language). Patient must be permitted to have a witness, of the patient's choice, present when the patient gives consent.

- Consent form must be signed by the patient, interpreter, if one is used, the person who obtained the consent, and the physician who will perform the procedure. In signing the consent form, the person obtaining the consent must certify that he/she advised the patient before the patient signed the consent form that no federal benefits may be withdrawn because of a decision not to be sterilized; orally explained the requirements for informed consent as set forth on the consent form and determined to the best of his/her knowledge and belief that the patient understood the content and nature of the informed consent process and knowingly and voluntarily consented to be sterilized. The interpreter must certify that he/she transmitted information orally to the patient, read and explained the form to the patient, determined to the best of his/her knowledge and belief that the patient understood the form, prior to signing the form. The physician, performing the sterilization, must certify, by signing the form, that the patient was informed, shortly before the performance of the sterilization, that federal benefits would not be withheld or withdrawn because of a decision to not be sterilized. After the appropriate time has passed after the date of the patient's signature on the form, stating he/she understands the procedure, the sterilization will be performed.
- A copy of the signed consent form must be provided to the patient and retained by the physician and the hospital in the patient's medical record.
- Unless an emergency abdominal surgery or premature delivery occurs, or the patient voluntarily requests in writing (Medi-Cal patients cannot request this) that the procedure be performed in less than 30 days, 30 days (but not more than 180 days) must pass after the sterilization consent form has been signed by the patient and other appropriate parties before the sterilization procedure can

be performed. However, in no case can sterilization be performed in less than 72 hours following the signing of a consent form. The physician must certify shortly before the procedure is performed that one of the above conditions has been met. Additionally, the physician must describe the emergency (for emergency abdominal surgery) or state the expected date of delivery (for a premature delivery) on the consent form.

- The above requirements apply only to elective sterilization.

- ***Immunizations:*** The federal National Childhood Vaccine Injury Act (42 U.S.C. 300aa-1 *et seq.*) requires that each health care practitioner, who administers one of several types of vaccines to any person, must provide to that person (or if a minor, to the parent or legal guardian) certain specified vaccine information materials regarding the benefits and risks of the vaccine prior to its administration every time a vaccine is administered. Vaccines for which this information must be supplied are diphtheria, tetanus, pertussis, polio, measles, mumps, and rubella. The information that must be given by health care practitioners to the legal representative of any child or to any other individual receiving one or more of the specified vaccines includes:
 - ⇒ A concise description of the benefits of the vaccine;
 - ⇒ A concise description of the risks associated with the vaccine;
 - ⇒ A statement of the availability of the National Vaccine Injury Compensation Program, and
 - ⇒ A copy of the CDC Vaccine Information Statement for the administered vaccine (VIS).
 - ⇒ The CDC VIS forms may be obtained in 14 languages from the vaccine information materials order line of the DHS at (800) 745-8477.

9. **Implied Consent:** There are three (3) exceptions to informed consent – (1) emergency situations, (2) patient requests not to be informed, and (3) therapeutic privilege. Implies consents may be used in the following situations:

- *Emergency situations:* (defined as requiring immediate services for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable medical conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death). If the patient is mentally incapacitated and there is

OFFICE PROCEDURES: Consent Policies (Cont'd)

no legally authorized representative who can consent on behalf of the patient, a patient will be presumed to have consented to necessary medical treatment. Treatment should not exceed what is necessary to address the emergency. The reasons why the exception was invoked will be documented in the medical record.

- *Patient requests not to be informed:* If the patient or patient's representative asks that he/she not be informed of the risks.
- *Therapeutic privilege/physician discretion:* In rare situations where a physician can prove that under the circumstances it was reasonable to believe that "the disclosure would so seriously upset the patient that the patient would not have been able to dispassionately weigh the risks or refusing to undergo the recommended treatment," the physician may withhold the information.

10. **Informed Refusal:** Applied to any recommended test, procedure, or medical recommendation, which has been refused. The physician must inform the patient who refuses to undergo the recommended procedure of the potential consequences. This informed refusal would be documented in the patient's medical record.

11. **Consent of Minors:** A written parental consent is required in order to treat a minor (under age 18) with the following exceptions:

- *Minors with divorced parents* – either parent may consent to treatment if parents have joint custody.
- *Adopted minors* – adoptive parents may consent to treatment.
- *Children of minor parent* – the minor parent may consent to treatment.
- *Minor pupil* – when the child is ill or has been injured during school hours and parents cannot be reached, the child may be treated without parental consent.
- *Minor in custody* – may be treated when ordered by the court.
- *Minor patients with legal capacity to consent to medical treatment.*
 - *Self sufficient minor* – defined as a minor 15 years of age or older living separate and apart from his/her parents or legal guardian and manages his/her own financial affairs, regardless of the source of income, is capable of giving valid consent. This minor will affirm the above conditions in writing.
 - *Emancipated minor per court order* – If the court order is obtained, the DMV issues an ID card, which states that the minor is

emancipated. A copy of this card will be placed in the patient's medical record.

- *Minors on active duty in the US Armed Forces*
- *Minors receiving pregnancy care (treatment or prevention)*
- *Minors 12 years and older suffering from a reportable disease relating to the diagnosis or treatment of that disease.*
- *Married minor with marital proof (marriage certificate).*

OFFICE PROCEDURES: Consent Policies (Cont'd)

- **Pregnancy (Civil Code Section 34.5).** In addition to the categories of minors who may consent for themselves, there are certain types of care for which minors of various ages may give their consent to treatment.
 - Any minor of any age may consent to hospital, medical or surgical care related to treatment or prevention of pregnancy, except for sterilization procedures.
 - It is up to the minor to decide whether or not to involve her parents in these decisions.
 - If a parent requests a copy of the minor's medical record, the physician may make the birth control or pregnancy information available only with the minor's authorization.
 - The physician may provide the parent with a copy of all information in the record except that pertaining to decisions on pregnancy or birth control.
 - (A practical hint would be to keep minor patient's birth control and pregnancy information on a separate sheet within the medical record).
- **Reportable Disease, Sexually Transmitted Disease (Civil Code Section 34.7)**
 - A minor age 12 or older may consent to hospital, medical or surgical care required to diagnose and treat any infectious, contagious, or communicable disease that is reportable to the local health officer.
- **Rape (Civil Code Section 34.8)**
 - A minor age 12 or older may consent to hospital, medical or surgical care related to the diagnosis and treatment of rape or alleged rape.

12. **Telemedicine Consent.** Defined as the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Before delivering any health care by telemedicine, a health care practitioner who has the ultimate authority over the care or primary diagnosis of a patient must obtain the patient's verbal and written informed consent. The informed consent procedure must ensure that at least all of the following information is given to the patient verbally and in writing:

- The patient has the option to withhold or withdraw consent at any time without affecting his or her right to future health care or

treatment, and without risking a loss or withdrawal of any program benefits to which the patient would otherwise be entitled;

- A description of the potential risks, consequences, and benefits of telemedicine;
- All existing confidentiality protections apply;
- The patient is guaranteed access to all medical information transmitted during a telemedicine consultation, and copies of this information are available for a reasonable fee; and
- Dissemination of any patient-identifiable images or information from the telemedicine interaction to researchers or others will not occur without the patient's consent.

The patient must sign a written statement before the delivery of health care by telemedicine, indicating that the patient understands the written information provided above and that this information has been discussed with the health care practitioner, or someone designated by him or her. This law does not apply when the patient is not directly involved in the telemedicine interaction (i.e., when one health care practitioner consults with another health care practitioner). However, all existing confidentiality protections for patient's medical information will continue to apply. The law does not apply in an emergency situation in which the patient is unable to give informed consent and the patient's representative is not available. The law also does not apply to a patient who is under the jurisdiction of the Department of Corrections.

13. **Consent Distribution:** A copy of the consent form must be given to the patient and a copy must be retained in the patient's medical record. Copies of court orders, etc. relating to the consent will also become part of the patient's medical record.

14. Sample forms follow.

Emergency Plan Procedures

Note to User: The sample policy below includes an underlined item for you to select or enter.

All staff members are trained on the following procedures. In case of an office emergency or disaster, staff members will immediately:

1. Assess the type and extent of emergency, if possible.
2. Assure that all staff, patients and visitors are evacuated to a safe place using emergency exits.
3. Assure personal safety.
5. Call (911/other number) and report disaster

OFFICE PROCEDURES: Emergencies and Consent

Policy

A medical emergency is defined as a situation where “treatment appears to be immediately required and necessary to prevent the patient’s death, sever disability, or deterioration or aggravation or the patient’s condition, or to alleviate severe pain”. When an emergency situation occurs, consent is necessary unless the patient is incapacitated and is either permanently or temporarily unable to come to an informed decision.

This could be due to:

- Injury of sudden illness
- Alcohol or drug intoxication
- Shock or trauma
- An underlying mental or physical disease or handicap

The practical consideration of medical treatment for emergencies is based on a legal concept called “implied consent”. The theory is that if the patient were able to consent to treatment, the consent would be given. Treatment is limited to that which is necessary to prevent:

- The patient’s death
- Severe disability
- Deterioration or aggravation of the condition
- Alleviate severe pain.

The emergency treatment exception does **not** apply if the patient has refused treatment because of his/her religious beliefs.

Procedure

1. If the patient is of age or is an emancipated minor, but is under the influence of drugs or sedatives, so that the patient might not be aware of what he/she is doing, the signature of the patient, if possible should be obtained **and** one of the following in the order given should sign:
 - Court-appointed guardian, if any
 - Spouse
 - Parents
 - If no parents, a brother or sister may sign.

OFFICE PROCEDURES: Emergencies and Consent (Cont'd)

2. Whenever treatment is being rendered on an emergency basis to a minor (male or female under the age of 18 whose parents or guardians have not accompanied them and may be away), the attending provider should:
 - Attempt to contact parents or guardians by phone
 - Use a phone line with an extension or a speaker phone
 - See that verbal consent is witnessed by another medical person listening on the extension or speaker
 - This should be documented on the consent form.

3. In the type of emergency situation in which consent for procedures cannot be obtained, the medical record should give clear indication of the nature of the emergency and the need to proceed with the procedures for the health and well being of the patient. The statement of **medical need must be signed by the physician performing the procedure.**

4. While there is no requirement that a provider obtain a consultation when he/she performs emergency treatment, it is a **good idea and recommended that a consultation with another physician be obtained.**
 - The consulting physician should document his/her findings in the patient's medical record.
 - The documentation should include the physician's determination that an emergency existed and the patient required treatment because...

OFFICE PROCEDURES: Office Security

Policy

It is office policy that all information contained in the medical record is private and will remain strictly confidential. A patient's medical record information cannot be released without the express consent of the patient. The office maintains a standard Consent to Release Medical Records Form, which must be reviewed, understood and signed by patients before release of patient's medical records (any part or entire record).

Procedure

1. The medical record belongs to the physician/practice, and will not be made public.
2. Only the physician, clinical, and administrative staff, who have a specific need, shall have access to and handle medical records.
3. All records will be maintained in the office, in a secure medical record storage facility. The facility is to be locked after hours. During normal business hours, only designated office staff members monitor the facility.
4. Information contained in the medical record is not to be discussed by or among employees, or with visitors unless there is a specific reason to do so. Such conversations are considered confidential.

(Note: The office should state its policy for releasing HIV/AIDS and STD information contained in medical records. Policy should reflect state law.)

All employees, consultants, and contractors who may have access to confidential information will be advised of their responsibility to maintain the confidentiality of all data and information, including but not limited to the private medical information of patients, as well as any information deemed proprietary.

5. All employees, consultants and contractors will be informed prior to employment or contract execution of the confidentiality of private medical information and the rules and regulations regarding their use. All employees are to receive instruction on procedures on the appropriate handling and safeguarding of confidential information and will be apprised of their responsibility for maintaining strict confidentiality of practice and client data

6. Only designated managers, staff, consultants and contractors will be authorized to review the medical records of patients seen by the practice. All such personnel are to be trained in the proper handling of medical records, and will continue to receive such training as necessary.

Sample

Affidavit of Confidentiality Statement Between <PRACTICE NAME> and <Employees, Consultants, and/or Contractors>.

I, the undersigned, have read and understand that the <PRACTICE NAME> Policy and Statement regarding the confidentiality of data and private medical information. I will abide by and conduct myself in accordance with confidentiality regulations, policies, and guidelines in the course of my activities and work with <PRACTICE NAME>.

I understand that any violation of confidentiality regulations and policies is grounds for termination and immediate dismissal from the practice or contract with the practice.

Signed _____ Date _____
Employee, Consultant, or Contractor

OFFICE PROCEDURES: Sterilization

Policy

To ensure instruments, supplies, and equipment are properly sterilized.

Procedures

1. Monthly bacteriological tests will be conducted per policy; results will be kept for one year.
2. Sterilizer thermometers will be checked and recorded daily; records will be kept for one year.
3. Preventative maintenance on sterilizer according to policy; log will be kept for one year.
4. Keep an effective separation of soiled or contaminated supplies and equipment from the clean and sterilized supplies and equipment. Sterile supplies and equipment will be handled in a manner that will minimize stress and pressure and stored in clean cabinets, cupboards or other appropriate spaces protected from dust, insects, vermin, temperature and humidity extremes. An orderly system of rotation of supplies will be used so that supplies stored first will be used first. (For offices with high volume speculum use, these items may be stored unwrapped). The following three types of sterilization will be used, as applicable:

- **Steam Sterilization**

- Items will be thoroughly cleaned with soap and water, rinsed, and dried. All jointed items will be opened and/or unlocked. Items designed for disassembly will be disassembled.
- Items will be placed in appropriate covering/wrapping and sealed with pressure/temperature sensitive indicator tape.
- Items will be positioned in a steam sterilizer to enhance air removal, allow free circulation and penetration of steam and prevent excessive condensation.

Time temperature settings recommended by the device manufacturer will be followed. Instruction for opening autoclaves and sterilizers will be posted in the area where they are located. Items should remain untouched until adequately cooled.

OFFICE PROCEDURES: Sterilization (Cont'd)

- When items are removed, indicator tape will be checked to determine if optimum exposure to steam.
- Flash sterilization will be used for emergency sterilization only of clean unwrapped instruments and porous items.
- Sterilizer indicating thermometers will be checked and recorded daily. Records of thermometer charts will be kept for up to one year. (If the autoclaves have computerized preset thermometers, this requirement is waived.)
- Monthly bacteriological tests will be conducted per test manufacturer frequency instruction, and records of results kept for up to one year. (3M test – Attest may be used for weekly test for the bacterial spore – *Bacillus Stearothermophilus*. It is recommended by AMA, JCAHO, CDC DORN).
- Preventive maintenance of sterilizer will be performed according to individual policy on a scheduled basis by qualified personnel, using the manufacturer's service manual for the sterilizer as a reference and a maintenance record kept for up to one year.

- **Cold Sterilization**

- Only activated high level disinfectant will be used; temperature 20 degrees C or higher and all items will be soaked for a minimum of 10 hours.
- Disinfectant solutions will be kept covered and used in a well ventilated area.
- Cold sterilization applies to heat sensitive items (i.e., non-metal, non-disposable vaginal speculums, anoscopes, scopes with light bulbs such as Cytoscopes, stainless steel instruments, etc.),
- Items will be thoroughly cleaned with soap and water, rinsed, and dried. All jointed items will be opened and/or unlocked. Items designed for disassembly will be disassembled.
- Items will be immersed completely in an activated high level disinfectant solution such as Cidexplus that is at a temperature of 20 degrees C or higher, and soaked for a minimum of 10 hours.
- Sterile forceps will be used to remove the items from the solution.
- Items will be rinsed with sterile water and placed on a clean drape or towel.
- Only sterilization disinfectant solutions will be used, and will be kept covered and used in a well ventilated area. An expiration date, determined according to manufacturer's written recommendations,

will be marked on the container of the disinfectant solution currently in use.

- **Gas Sterilization**

- Applies to heat sensitive items (i.e., plastic items).
- Procedure must be performed in a well aerated area.
- Environmental protection procedures will be followed.
- Length of time for materials gas sterilized must be monitored.
- Ethylene Oxide is an example of the type of gas used.
- Provision must be made for safe handling and storage of medical gas cylinders.

OFFICE PROCEDURES: Reporting Violence and Abuse

Policy

When a healthcare practitioner (in his/her professional capacity) observes that a person has been injured or killed by a violent act, or where there is reason to suspect assault or abusive conduct by a domestic partner, that practitioner will report these observations by telephone and follow up with a written report to the local law enforcement agency. Assault or abusive conduct is defined to include any number of prohibited criminal acts or attempted acts such as assault with a deadly weapon, murder, manslaughter, mayhem, rape, spousal rape, battery, sexual battery, etc. (Penal Code 11160(d)(1)-(d)(24)). Domestic violence can occur between unmarried or married, cohabitating or not, heterosexual homosexual.

Procedures

1. Health professionals will report suspected assault or abusive conduct.
2. A written report must be sent to the local law enforcement agency within two (2) working days.

3. **Guidelines for Assessment**

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 any 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 finds.

- Minor lacerations, contusions, abrasions, fractures or sprains
- Injuries to the head, neck, chest, breasts, or abdomen
- Injuries during pregnancy, such as spontaneous abortions
- Multiple injury sites
- Chronic or repeated injuries
- Medical problems which indicate chronic or psychogenic pain
- Physical symptoms related to stress, anxiety disorders or depression
- Chronic diseases such as asthma, seizures, arthritis, etc.
- Multiple gynecological problems
- Frequent use of prescribed minor tranquilizers or pain medications
- Psychiatric symptoms such as panic attacks, substances abuse, inability to cope, feelings of isolation, suicidal tendencies
- Behavioral problems such as an appearance of fright, shame or embarrassment

OFFICE PROCEDURES: Reporting Violence and Abuse (Cont'd)

4. Documentation of Abuse

Well-documented medical records must be maintained by the healthcare practitioner and should include the following information:

- Name of the injured person
- Location of injured person
- Extent and character of the person's injuries
- Identify of the person the injured person alleges inflicted the wound(s), other injury(s), or assault or abusive conduct upon the injured person
- Description of the abusive event or description of the major complaints in the injured person's own words, whenever possible
- Medical and relevant social history of the injured person
- Map of the location of the injuries on the victim's body documented at the time of the health care service
- A copy of the law enforcement reporting form

5. Reporting

- The healthcare practitioner should keep in mind that the abused or battered woman/man is often at greatest risk immediately after the police are first called, and after the police leave the scene. Prior to reporting instances of spousal abuse, the practitioner may wish to encourage the patient to locate a protected environment for herself/himself and children (if applicable), rather than run the risk of being in the same hostile environment he/she was in when the police were first called. Practitioners should obtain information on battered women's/men's shelters in the local area, as well as information on counseling programs for both victim and batterer to utilize in these instances.
- The telephone report must be made immediately or as soon as practically possible, and must be followed up with a written report to the local law enforcement agency within two (2) working days of receiving the information regarding the injured person. The written report must be on a standardized form and include the name of the injured person, location of injury, extent of injury, description of how the person was injured, and identity of the person inflicting the injury, if known. To be reportable, the injury must be current and the patient still suffering from it. If two or more persons are required to report the

same incident, they may agree among themselves as to one reporter. No person who is obligated to report may be inhibited or impeded in his or her reporting duties by any supervisor or administrator.

- There are no Penal Code statutes prohibiting verbal or mental abuse per se or the psychological injuries arising out these acts, so healthcare practitioners are not legally obligated to report such cases.

OFFICE PROCEDURES: Reporting Violence and Abuse (Cont'd)

6. Immunity

The law provides immunity for healthcare practitioners from civil and criminal liability for reports of known or suspected instances of abuse. Healthcare practitioners (or their agents) are also immune from liability for taking or causing to be taken photographs of the suspected victim of domestic violence and for forwarding the photographs with the mandated report. Further, a healthcare practitioner who, pursuant to a request from an adult protective services agency or a local law enforcement agency, provides the requesting agency with access to the victim of a known or suspected instance of abuse, shall not incur civil or criminal liability as a result of providing that access. In addition, in the event that a person required to report is required to defend a legal action based on the making of the report and prevails, the state will reimburse the individual's reasonable attorney's fees (not to exceed an hourly rate greater than the rate charged by the attorney general at the time the award is made, up to a maximum of \$50,000).

7. Penalties

Failure to report domestic violence abuse is a misdemeanor punishable by up to six (6) months in jail and/or up to a \$1,000 fine.

8. Practitioner Domestic Violence Training

Legislature now requires that physician applicants for licensure who have matriculated at medical school on or after September 1, 1994 must show that they have training or coursework in spousal abuse detection and treatment. (Business and Professions Code 2089)

OFFICE PROCEDURES: Reporting Child Abuse/Neglect

Policy

To ensure child abuse cases are recognized, diagnosed, reported as soon as practical by telephone and followed up with a written report.

Procedure

1. Signs and symptoms of abuse and neglect should be identified by the healthcare practitioner according to the following indicators:
 - **Physical Abuse** (physical injury inflicted on a child by another person by other than accidental means)
 - Bruises or welts that have a regular pattern resembling the shape of an article which might have been used to inflict the injury.
 - Burns that appear to be from a cigar or cigarette especially on the soles of the feet, palms, back or buttocks; patterned burns and immersion burns.
 - Abrasions such as rope burns or lacerations especially on the wrist, ankles, torso, palate, mouth, gums, lips, eyes, ears, external genitalia.
 - Fractures, many times at different stages of healing to the skull, ribs, or long bones.
 - Injuries to the abdomen, kidney, bladder or pancreas; intestinal perforation; ruptured liver, spleen or blood vessels; or intramural hemotoma of the duodenum or proximal jejunum.
 - Symptoms of suffocation or chemical abuse or indicators pointing to Munchausen syndrome by proxy.
 - **Sexual Abuse** (includes both sexual assault and sexual exploitation)
 - Bruises or abrasions to the inner thighs or external genitalia
 - Attenuation or distortion of the hymen
 - An alternation of anorectal tone
 - Evidence of sexually transmissible disease

Pregnancy (although pregnancy alone is not sufficient to constitute the basis of a reasonable suspicion of sexual abuse)

OFFICE PROCEDURES: Reporting Child Abuse/Neglect (Cont'd)

- Willful Cruelty or Unjustifiable Punishment of a Child
Unlawful Corporal Punishment or Injury
- **Neglect** (negligent treatment or maltreatment of a child by a person responsible for the child's welfare where harm to the child's health or welfare is indicated or threatened)
 - History of lack of appropriate well-child care
 - Failure of a child to thrive
 - Malnutrition, untreated medical conditions, poor hygiene, rampant dental caries
 - Behavioral indicators such as anxiety, depression, sleep disturbances, enuresis, excessive masturbation, aggressive behavior, excessive household responsibilities for age including child care, poor school performance, discipline problems and impaired personal problems.
- **Abuse in Out of Home Care** (all cases of abuse as defined above in a child care, school, or other agency or institutional setting)

2. **Diagnosis**

A thorough health assessment must be conducted by the physician, which includes a history, physical examination and developmental assessment on a child who may be a victim of abuse. The Office of Criminal Justice Planning (OCJP) determines the protocols for performing physician examinations on a victim of sexual assault, including child molestation (for additional information on these protocols, consult (916) 324-9120). X rays, CT scans, bone scans, or other laboratory studies are of use in determining and defining the current trauma, previous traumas and excluding other medical conditions. In cases of suspect child abuse, a physician, surgeon, or dentist (or their agents) may take x-rays without parental consent.

The following diagnostic process should be performed:

- An assessment of the child's immediate medical needs
- Compilation of the past medical and social history of the child and family members
- Assessment of the plausibility of the history being provided in light of pre-existing medical conditions
- Determination of how great a risk it would be if the child returns home

3. Reporting

- A report must be made immediately or as soon as possible by telephone to a police or sheriffs department, a county probation department or a county welfare department. The report must include the name of the person making the report, the name of the child, the present location of the child, the nature and extent of the injury, and any other information, including information that let the person to suspect child abuse, requested by the child protective agency.
- The written report must be on a standardized form which should be available from child protective services agencies and must be sent within 36 hours of notice of the abuse. Special forms must be used by physicians who conduct an examination for sexual assault in an acute care hospital. Three forms which are recommended for reporting child abuse cases are as follows:
 - ⇒ "Suspected Child Abuse Report" form SS 8572 which may be obtained from the local child protective service agency
 - ⇒ "Medical report – Suspected Child Abuse" form DOJ 900 which may be obtained from the local child protective agency
 - ⇒ "Medical Report – Suspected Child Sexual Abuse" form OCJP 925, available by calling the office of Criminal Justice Planning at (916) 323-7428, or by writing to OCJP, 1130 K Street, Suite 300, Sacramento CA 95814

OFFICE PROCEDURES: Reporting Child Abuse/Neglect (Cont'd)

4. Immunity

The law provides immunity for healthcare practitioners, from civil and criminal liability, for reports of known or suspected instances of abuse. Healthcare practitioners (or their agents) are also immune from liability for taking or causing to be taken photographs of the suspected victim of child abuse without parental consent, and for forwarding the photographs with the mandated report. In addition, in the event that a person required to report is required to defend a legal action based on the making of the report and prevails, the state will reimburse the individual's reasonable attorney's fees (not to exceed an hourly rate greater than the rate charged by the attorney general at the time the award is made, up to a maximum of \$50,000).

5. Penalties

Failure to report child abuse is a misdemeanor punishable by up to six months in jail and/or up to a \$1,000 fine. A healthcare practitioner may also be liable in civil court for damages, which occur if the child is further victimized because of a failure to report the abuse.

6. Employee Statements

Physicians and other employers who hire licensed healthcare practitioners or other mandated reports must obtain a signed statement from those employees hired on or after January 1, 1985, attesting to the employees' understanding of their child abuse reporting obligations per Penal Code 11166.5). Employers must retain these signed statements at the employer's expense.

OFFICE PROCEDURES: Reporting Elder and Dependent Adult Abuse

Policy

To report physical injury or condition appearing to be the result of physical abuse, abuse of financial affairs, neglect or abandonment of an elder or dependent adult, in accordance with state laws, to the local law enforcement agency and Department of Health. (Welfare and Institutions Code Section 15600-15659)

Physical abuse means a situation where any person who has the care or custody of or who stands in a position of trust with an elder or dependent adult, willfully inflicts upon that elder a cruel or inhumane corporal punishment or injury.

- **Abuse**

Physical abuse, neglect, intimidation, cruel punishment, fiduciary abuse, abandonment, or other treatment with resulting physical harm or pain or mental suffering, or the deprivation by a care custodian of goods and services which is necessary to avoid physical harm or mental suffering. All health care professionals and care givers, health educators, designated employees of adult protective services agencies and designated employees of local law enforcement agencies are required by law to report incidents of suspected abuse (i.e., physical abuse, sexual abuse, fiduciary abuse, neglect, abandonment, and isolation) of any elder or dependent adult. **An immediate phone report is required** to a 24 hour crisis line at the Department of Aging at 800-231-4024. A written report (Department of Social Services form SOC341) must be sent within 48 hours to either the long term care ombudsman coordinator or to a local law enforcement agency when the abuse is alleged to have occurred in a long term care facility; or to either the county adult protective services agency or to a local law enforcement agency when the abuse is alleged to have occurred anywhere else.

- **Physical Abuse**

Assault, battery, assault with a deadly weapon or force likely to produce great bodily injury, unreasonable physical constraint or prolonged or continual deprivation of food or water, use of a physical or chemical restraint or psychotropic medication (for punishment, for a period beyond that for which the medication was ordered pursuant to the instruction of a licensed physician and surgeon, for any purpose not authorized by the physician and surgeon), and sexual assault.

- **Sexual Assault**

Assault and battery, rape, rape in concert, incest, sodomy, oral copulation, penetration of the genital or anal opening by a foreign object.

- **Physical Abuse Indicators**

- Multiple injury sites, bruises or welts that have a regular pattern resembling the shape of an article which might have been used to inflict the injury.
- Burns that appear to be from a cigar or cigarette,
- Injuries to the head, neck, cheek, breasts or abdomen, contusions, abrasions such as rope burns or lacerations especially on the wrist, ankle, torso or extremities,
- Fractures, many times at different stages of healing, to the skull, ribs, or long bones, Injuries to abdomen, kidney, bladder or pancreas, intestinal perforation, ruptured liver, spleen or blood vessels, spontaneous abortions resulting from injury to the abdomen. Intramural hematoma of the duodenum or proximal jejunum.
- Chronic diseases such as asthma, seizures, arthritis, etc.,
- Medical problems indicating chronic or psychogenic pain,
- Symptoms of suffocation and chemical abuse,
- Improbably explanation of injuries or major inconsistencies between elder or dependent adult and caregiver's injury etiology description,
- Changes in the elder or dependent adult's behavior when the caregiver enters or leaves the room,
- Appearance of fright, shame or embarrassment, depression, agitation, stress, inability to cope, panic attacks, feelings of isolation, withdrawal, homicidal or suicidal tendencies,
- Frequent use of prescribed tranquilizers or pain medications,
- Risk factors such as caregiver substance abuse or historical family violence.

OFFICE PROCEDURES: Reporting Child Abuse/Neglect (Cont'd)

- **Sexual Abuse**
 - Bruises or abrasions on the inner thighs or external genitalia,
 - Alteration in anorectic tone,
 - Evidence of a sexually transmitted disease,
 - Multiple gynecological problems,

- **Fiduciary Abuse**

A person who stands in a position of trust, with respect to an elder or dependent adult, and willfully steals the money or property of that elder or secretes or appropriates the money or property of that elder to any use or purpose not in the due and lawful execution of his or her trust (inclusive of misappropriation of Social Security funds) is committing abuse.

- **Neglect**

Failing to care for an elder or dependent adult to the degree of care which a reasonable person in a like position would exercise constitutes neglect. Indicators may include:

 - Historical or current lack or delay of appropriate care,
 - Failure to protect from health and safety hazards,
 - Malnutrition, untreated medical conditions, weight loss,
 - Failure to provide physical aids (i.e. eyeglasses, hearing aids, dentures and/or ambulatory assistive devices),
 - Signs that the caregiver has been unwilling or unable to provide assistance with daily living skills (i.e., poor hygiene, lack of appropriate clothing, lack of proper diet, urine stains on clothing, etc).

- **Abandonment**

The desertion or willful forsaking of an elder or dependent adult by any person having the care or custody of that elder or dependent adult under circumstances in which a reasonable person would continue to provide care or custody.

OFFICE PROCEDURES: Reporting Child Abuse/Neglect (Cont'd)

- **Isolation**

- Acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his/her mail or telephone calls
- False imprisonment
- Physical restraining of an elder or dependent adult for the purpose of preventing them from meeting with visitors
- Telling a caller or prospective visitor that an elder or dependent adult is not present, or does not wish to talk with the caller, or does not wish to meet with the visitor where the statement is false, is contrary to the express wishes of the elder or dependent adult, whether he/she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons.

- **Dependent Adult**

A person between the ages of 18 and 64, who has physical or mental limitations, which restrict him or her from carrying out normal activities of protecting his or her rights, (including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age) may be a dependent adult, A dependent adult can also include any person between the ages of 18 and 64 who is admitted as an inpatient to a 24 hour health facility as defined in Section 1250, 1250.2 and 1250.3 of the Health and Safety Code.

- **Elder** means any person 65 years of age or older.

Procedure

1. A thorough assessment must be conducted by the physician, which includes a history and physical examination of the elder or dependent adult suspected of being a victim of abuse. For known or suspected sexual assaults, examination protocol per Penal Code 13823.5, 13823.7, 13823.9 and 13823.11 must be followed. X-rays, CT scans, bone scans or other laboratory studies are of use in determining and defining the current trauma, previous traumas and excluding other medical conditions. The following diagnostic process should be performed:

OFFICE PROCEDURES: Reporting Child Abuse/Neglect (Cont'd)

- An assessment of the elder or dependent adult's immediate medical needs,
- Compilation of the past medical and social history of the elder or dependent adult and family members (if applicable),
- Assessment of the plausibility of the history being provided in light of pre-existing medical conditions.
- Determination of how great a risk it would be if the elder or dependent adult were to return to their living situation or residence.

Medical Record Documentation

Medical Record documentation, maintained by the health care practitioner, should include but not be limited to the following:

- Name of abuse victim,
- Date/time abuse became known,
- Physical assessment/evaluation, location, extent and character of injuries,
- Map of the location of the injuries on the abuse victim's body, documented at the time of the health care service,
- Name/identify of alleged abuser
- Description of the abusive event or abuse victim complaints (in their own words),
- Medical and relevant social history of the abuse victim,
- Health practitioner follow up (i.e., reporting, etc.).

Reporting

Reporting is required of physicians, nurses, pharmacists and all other medical practitioners licensed under Division 2 of the Business and Professions Code. It is also required of certain non-medical practitioners, such as coroners, social workers, psychologists, family counselors, nursing home ombudsmen, care custodians, law officers and probation and welfare personnel. The law does not extend to members of a physician's office support staff who is not licensed healthcare practitioners. One individual may make the required report for an entire group, and facilities may develop reporting protocols, so long as they are consistent with the statutory requirements. Reporting is required for physical abuse as defined above. Those required to report, may but are not required to report, known or reasonably suspected instances of other types of abuse, including cases of mental abuse, fiduciary abuse,

neglect, abandonment, isolation or other treatment with resulting physical harm or pain or mental suffering, or the deprivation by care custodian of goods or services that are necessary to avoid physical harm or mental suffering.

Telephone Report

The telephone report must be made immediately or ASAP when reporter has knowledge or reasonable suspects that abuse has occurred, to:

- The long-term care ombudsman coordinator (when the abuse is alleged to have occurred in a long-term care facility),
- State Department of Mental Health, State Department of Developmental Services, or to a local law enforcement agency (when the abuse is alleged to have occurred in a state mental hospital or state developmental center),
- County Adult Protective Services Agency or County Welfare Department (when the abuse is alleged to have occurred anywhere else).

Report Requirements

The report should include the name of the person making the report, the name, address and age of the elder or dependent adult, the nature and extent of the dependent adult or elderly person's condition, present location of the elder or dependent adult, the names and addresses of family members or any other person responsible for the elder or dependent adult, (if known), the alleged incident of elder or dependent adult abuse and any other information including what led the person to suspect elder or dependent adult abuse. The 24-hour toll-free number for the Department of Aging Crisis Hotline is 800-231-4024.

A written report must be completed within 48 hours of the telephone report, on a California Department of Social Services form SOC341 entitled "Report of Suspected Elder or Dependent Adult Physical Abuse," and mailed to the address indicated by the agency that took the phone reports, and the county department of adult protective services. This form is obtainable from the County Adult Protective Services Agency or the local long-term care ombudsman program.

OFFICE PROCEDURES: Reporting Child Abuse/Neglect (Cont'd)

- The law provides that care custodians, health practitioners, or employees of adult protective services agencies or local law enforcement agencies will not incur either civil or criminal liability for any report they are required or permitted to make under this law. However, any person who knowingly fails to report, when required, an instance of elder abuse is statutorily guilty of a misdemeanor punishable by a fine not to exceed \$1,000, or imprisonment in the county jail exceeding six (6) months or both. A healthcare practitioner may also be liable in civil court for damages that occur if the elder or dependent adult is further victimized because of failure to report the abuse.

Endangered Adults Laws

Physicians should ascertain whether the Protective Placement and Custody Laws have been adopted in their county by calling their local county medical society, law enforcement agency, adult protective services department of local county governing body. These laws provide that if a physician treating an adult determines that the person is an endangered adult (defined as in a situation posing an immediate risk of serious injury or death, when no other means are available to mitigate the risk to the individual), whether or not medical treatment is required, the physician may (but is not required to) delay the release of the endangered adult until the following:

- A local law enforcement agency takes custody of the endangered adult,
- It is determined by the responding agency the adult is not endangered,
- The responding agency takes other appropriate action to ensure the safety of the endangered adult.

In these instances, the physician must immediately notify local law enforcement of the delayed release decision, and request immediate assistance in the matter. Note – there are no explicit immunities for the physician in the event the presumed endangered adult or his or her family or guardian sues the physician for damages arising from the delayed release.

Employee Acknowledgement Form

Physicians or other employers who hire licensed health care practitioners or other mandated reporters on or after January 1, 1995, are required to obtain a signed statement to the effect that the employee has knowledge of the mandated reporter statute and will comply with its provisions. Employers must retain the signed statements at the employer's expense. In addition, employers must inform licensed healthcare practitioners and other mandated reporters in their employee who were hired prior to January 1, 1995 of their reporting responsibility. Effective with physician licenses issued on or after January 1, 1995, the Medical Board must obtain an acknowledgement that the physician understands and agrees to comply with the dependent and elder abuse reporting statutes.

- Reporting is done to the following or to local Law enforcement/Police:
 - Adults (60+ years, living independently)
[Adult Protective Services](#)
[1725 Technology Dr.](#)
[San Jose, CA 95110](#)
 - Adults (18-59 years, living independently)
Adult Protective Services
591 N. King Rd.
San Jose, CA 95133
Hotline: (800) 414-2002 Fax: (408) 923-2134
 - Adults (in RCH)
Long Term Care Ombudsman – Catholic Charities
2625 Zanker Rd., #200
San Jose, CA 95134-2107
(408) 944-0567 9am to 5pm
(800) 231-4024 after 5pm

MEDICAL RECORDS: Requirements and Standards

Policy

All providers shall maintain medical records in accordance with the most recent National Committee for Quality Assurance (NSQA) standard. A manner that is current, detailed, organized, permits effective patient care and quality review and maintains confidentiality.

Procedure

1. The medical record will be filed using a systematic method for easy retrieval, such as alphabetical or numerical filing, preferably color coded.
2. The medical record system must allow for prompt retrieval of medical records and availability to the provider at each patient encounter.
3. The medical record system must allow for the tracking of the record when it is out of the filing system and must have a system for the incorporation of information in the chart between visits as well as a system for the archiving of purged data.
4. Medical records will be inaccessible to patients and other unauthorized persons and will be maintained to guard against unauthorized disclosure of confidential information and will protect confidentiality.
5. There is a medical record for each member seen by an IPA contracted provider.
6. All pages in the record will be securely anchored and all pages will be filed chronologically.
7. Each page in the record contains the patients name or patient ID number for patient identification.
8. Personal/biographical and demographic data included age, sex, address, telephone number, marital status, and is updated as appropriate.
9. A copy of a consent to treat form is maintained in the medical record.

10. The medical record will document all aspects of patient care, including use of ancillary services.
11. All entries are dated.
12. The author of all entries is identified, including title.
13. The records are legible, documented accurately, and in a timely manner.
14. Allergies and adverse reactions are prominently noted on the record.
Absence of allergies (no known allergies or NKA) is noted if the member has no allergies.
15. Past medical history is recorded and easily identified, including serious accidents, operations, illnesses. For children, past medical history also includes birth information and mother's prenatal care.
16. A record of immunizations is documented for all age groups. For immunizations the lot number, date, time, site and education given to parents must be documented.
17. For Pediatric records (age 12 and under), there is a completed immunization record, plotted growth charts and documentation of neurological milestones.
18. For members 12 years and older, there must be a notation concerning cigarettes, alcohol, substance use, and anticipatory guidance.
19. All medications currently used must be listed. Medications prescribed must list name, dosage, frequency, duration. Medications given on-site must list name, dosage, site given.
20. Identification of current problems and significant illnesses, medical conditions, and health maintenance concerns are identified in the medical record.
21. The reason for the visit is noted, i.e., the chief complaint (s).
22. A history and physical examination with appropriate subjective and objective information must be obtained for the presenting complaints.
23. Appropriate vital signs are documented at each visit.

24. Diagnostic information and a plan of treatment for each visit are to be documented.
25. Treatments, procedures, and tests, including results are to be documented and consistent with treatment.
26. There is a specific follow-up date for a return visit or other follow-up plan for each encounter.
27. Referrals to specialty consultants and/or ancillary services are documented.
28. There must be evidence that there is continuity and coordination of care between the primary and specialty physicians.
29. Lab, pathology, and x-ray reports filed in the chart are to be signed or initialed by the provider signifying they have been reviewed.
30. Consultation and abnormal lab and/or imaging results have an explicit notation in the record for follow-up plans.
31. Discharge summaries, Emergency Department reports, Specialty consultation reports, and specialty follow-up care notes must reflect the providers review. The documents are to be filed in on the chart within two weeks of service.
32. There must be evidence of that failed appointments are followed-up on.
33. Patient health education, recommendations, instructions, and referrals are to be documented.
34. Preventive services are to be evident and appropriately used.
35. Documentation of whether the patient has executed an Advance Directive (a written instruction such as a Living Will or Durable Power of Attorney for health care relating to the provision of health care when the individual is incapacitated) or notation that information about Advance Directives was given to the patient as required by Federal Law.
36. If appropriate, a human sterilization consent form (PM330) will be filed in the patient's medical record.
37. Initial health assessments and Child Health and Disability (CHDP) screenings must be documented.

38. A copy of the CHDP PM 160 form will be placed in the medical record (CHDP Providers only).
39. The Health Behavior Risk Assessment will be completed for each member during the first appointment with the Primary Care Physician (Medi-Cal members only).
40. Standardized forms for documenting prenatal care will be used. Forms include documentation of medical, psychosocial, nutritional and educational assessments, interventions, and referrals for prenatal services (Comprehensive Prenatal Services Program [CPSP] Providers only).
41. Adult medical records must be stored for seven years (7). Pediatric medical records must be stored until the child is 21 years of age (current State and Federal requirements).

MEDICAL RECORDS: Information Confidentially and Access to Records

Policy

The medical records are secure and accessible only to authorized personnel in order to prevent loss, tampering, disclosure of information, alteration, or destruction of the record. Authorized personnel are those employees within the physician's office, health plan and medical group or persons authorized through a legal instrument (i.e., subpoena).

Procedure

1. Active medical records are to be stored in one central medical records area that is accessible only to authorized personnel.
2. Only assigned personnel, responsible for the maintenance of medical records, will have access to medical records.
3. Contract practitioners/provider's contracts will explicitly state expectations about the confidentiality of member's information and records.
4. All staff with access to medical records must have a signed confidentiality agreement on file in the provider's office.
5. All medical records and member information shall be stored and/or disposed of in a manner that continues to protect confidentiality. All medical records and member information will be disposed of or destroyed in a way such that information is not identifiable (e.g., shredded), when it is no longer in use, unless it is retained for regulatory purposes. (SB 19)
6. Disposal of records will be done in a confidential manner (i.e. professional shredding).
7. Unauthorized sharing of medical information is prohibited.
8. (SB 19) Providers are expressly prohibited from:
 - Negligent disposal of medical information.

- Intentional sharing, sale or use of medical information for any purpose other than to provide health care services to the member, except as otherwise authorized.
9. Providers are prohibited from requiring a patient, as a condition to receive services, to sign an authorization, release or consent or waiver permitting the disclosure of any medical information, in accordance with requirements to maintain confidentiality. (SB 19)
10. A health care service plan or provider of health care may disclose medical information for the purpose of disease management as follows:
- Any entity contracting with a health care service plan or the health care service plan's contractors to monitor or administer care of enrollees for a covered benefit, provided the disease management services and care are authorized by a treating physician,
 - Any disease management organization that complies with the physician authorization requirements of Health and Safety Code Section 1399.902, provided that the health care service plan, or its contractor, provides or has provided a description of the disease management services to a treating physician or to the health care service plan's or contractor's network of physicians. (AB 2414) Confidentiality of Medical Information Act (Civil Code Section 56.10(c)(17))
 - A provider of health care, health care service plan, or contractor is prohibited from disclosing medical information unless the member has signed an authorization. Except in certain specific circumstances, disclosure of medical information by providers of health care, health care service plans, or contractors is mandated under Civil Code Section 56.10(a) and Civil Code Section 56.10(b)
 - A provider of health care, health care service plan, or contractor is not permitted to disclose medical information without the patient's authorization to providers of health care, health care service plans, or contractors:
 - For purposes of diagnosis or treatment of the patient. Civil Code Section 56.10(c)(1)

- To an insurer, employer, health care service plan, employee benefit plan, governmental authority, contractor or any other person or entity responsible for paying for health care services rendered to the patient, to the extent necessary to allow responsibility for payment to be determined and payment to be made. Civil Code Section 56.10(c)(2)
- To an independent medical review organization and their reviewers (AB2094), Civil Code Section 56.10(c)(4)
- Except to the extent expressly authorized by the patient or as provided in Civil Code Section 56.10(b) and (c), no corporation and its subsidiaries and affiliates shall intentionally share, sell or otherwise use any medical information for any purpose not necessary to provide health care services to the patient. (SB1903) Civil Code Section 56.10(d)
- Further disclosure of medical information regarding a patient or the provider of health care or an enrollee of a health care service plan. (SB1903) Civil Code Section 56.10(e)

11. Medical records are only released under the following conditions:

- Patients, attorneys, or representatives of the patient or attorney receive a copy of the medical records only after presenting a signed authorization from the patient or his/her legal representative.
- The patient presents identification when requesting a copy of their medical record.
- With patient authorization, outside health care providers, Federal, State, County, or City agencies, employers, insurance companies or their representative may receive a copy of the patient's record.
- With a subpoena, an officer of the Federal, State, or municipal court may gain access to a patient's records.
- Agencies such as the FDA or other authorities that comply with reporting requirements in Title 17 of the California Code of Regulations also may gain access to confidential information.
 - Any release of information in response to a court order or to other authorized persons is to be reported to the patient within five (5) working days.

12. Member records are available, whether or not authorized by the enrollee, to qualified personnel for the purpose of conducting scientific research. However, to prevent divulging confidential information, the reports received for research are not to identify, directly or indirectly, any individual patient or otherwise disclose a participant's identity in any manner.
13. For the purpose of sharing enrollee information with any organization with which the enrollee may subsequently enroll, the provider/ organization must provide copies of all the patient's records to the new provider in order that they are available upon the enrollee's request. Further, it must be delivered in a timely fashion so to not impede continuity of care. (QISMC 3.6.4)
14. When requesting participation in outpatient behavioral health treatment, the requesting provider shall submit a written request to the provider of services and notify the patient of the specific confidential information requested. (AB416) (see following sample consent forms).
15. Only assigned personnel responsible for the maintenance of medical records may provide written documents or copies of patient records.
16. Authorization forms permitting release of medical records specify to whom the information may be released, the type of information being requested, the date and signature of the patient or representative. The patient's name, medical record number, name and organization of the requester, date of request, and the date the record was released is documented and filed in the patient's medical record.
17. Minors have the right to confidential services without parental consent. Therefore, medical records and/or information regarding medical treatment, specific to defined confidential services, cannot be released to parent(s) without the minor's consent.
18. All medical records released to authorized parties are legible documents.
19. Members will be given the opportunity to approve or refuse the release of identifiable personal information, except when such release is required by law.
20. No confidential patient information will be disclosed by means other than hard copies of medical records. (i.e. no information may be released over the telephone).

21. All patient medical records obtained for use by the health plan or medical group for Utilization Management, Quality Management, or claims purposes are protected from disclosure.
22. Physicians may request a reasonable reimbursement for the cost of copying a member's medical records.
23. Sample Medical Information Release Forms are found under "Medical Records: Confidentiality".

MEDICAL RECORDS: Confidentiality

Policy

Medical records are kept confidential under the California statute “Confidentiality of Medical Information Act, Civil Code §56 et seq. This Act prohibits disclosure of medical information absent an authorization signed by the patient or the patient’s legal representative.

Procedure

Offices shall maintain a policy of strict confidentiality regarding all patient care matters. Personnel are required to follow these guidelines:

1. Members will have access to their medical information.
2. Medical information will not be disclosed without the consent of the member.
3. Providers of health care shall allow adult patients who inspect their medical records pursuant to Health and Safety Code Section 123110 to provide a written addendum to the records if the patient believes the records are incomplete or inaccurate. This addendum is limited to 250 words per incomplete or incorrect item and must be attached to the patient records and included when disclosed to other parties. (Health care providers are not subjected to liability for the receipt and inclusion of these addenda in patient records). (SB1903) Health and Safety Code Section 123111.
4. Authorization forms permitting release of medical records specify to whom the information may be released, the type of information being requested, the date and signature of the patient or representative. The patient’s name, medical record number, name and organization of the requester, date of request, and the date the record was released is documented and filed in the patient’s medical record.
5. No psychotherapy outpatient treatment will be disclosed without written consent by the member and the member will be notified of the request.
6. Members will be given the opportunity to consent to or deny the release of medical information, except as required by law.

7. Disclosure of patient medical records by a physician is permitted without patient authorization when authorized by law.
8. Disclosure of medical information will be given to the extent to secure payment to insurers, employers, health plans, government entities, or other responsible for payment for services,
9. Physicians may request a reasonable reimbursement for the cost of copying a member's medical records.

MODEL LETTER TO A PATIENT WHO REQUESTS WITHHOLDING OF INFORMATION FROM DISCLOSURE

[Date]

CONFIDENTIAL

Patient's Name

Address

City, State Zip

Re: Release of Medical Information

Dear Patient:

I am in receipt of both your general authorization for release of your medical records (*insert entity name*) and of your request that certain information in the record not be disclosed. I understand the need for confidentiality concerning the medical information in your file. The principal California statute governing confidentiality of medical information is the Confidentiality of Medical Information Act, Civil Code §56 et seq. Generally speaking, this Act prohibits disclosure of medical information absent an authorization signed by the patient or the patient's legal representative. **Except as authorized by this statute and other relevant laws, I will not release information regarding your medical condition and treatment without having first obtained your prior written authorization.**

However, you should be aware that if you refuse to permit disclosure of certain information to certain entities, this may make it impossible for me to respond to requests from such entities for your health care records. For example, if you apply for life or health insurance coverage, such insurers will, no doubt, ask you to authorize release of your health care records as part of the application process. If you then notify me that, despite the general authorization which you signed, you do not want selected information disclosed, I will not be able to assist you in your effort to obtain insurance coverage. I cannot disclose only a portion of your medical information without notifying the insurer that a position of the file has been withheld, at the patient's request.

If the information you do not wish disclosed is covered by a special statutory confidentiality protection, the situation will be different. If that is the case, I may disclose your general medical information (without the specially protected information) and provide the entity with a boilerplate notification as part of the disclosure, which states:

“This disclosure does not contain information, if any exists, that is protected by special state and/or federal confidentiality requirements. Such information, if it exists, can only be released pursuant to special patient authorization.”

If you believe that the information you wish to withhold is covered by such a special protection, please notify me of that protection immediately and, if appropriate, I will disclose the information other than that which is specially protected, along with the boilerplate notification listed above. You should be aware, however, that upon receiving such a notice, the insurer or other entity will almost certainly ask you to sign a specific authorization for disclosure of the otherwise confidential information.

Please note also that the law allows physicians to share medical information for both treatment and billing purposes, even absent a patient’s written consent. Moreover, the law **requires** physicians to share medical information under some circumstances (e.g., pursuant to a valid court order).

SAMPLE AUTHORIZATION TO TRANSFER MEDICAL RECORDS

I hereby authorize _____, M.D., to furnish medical information concerning _____ (*patient's name*) to Dr.

(*physician's name and address*).

Any and all information may be released, including, but not limited to, mental health records protected by the Lanterman-Petris_Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below:

[Optional: I understand and agree to pay a reasonable charge to cover the cost of the transfer. I understand the costs will be computed based on a copying fee of \$.25 cents per page for standard documents, actual costs for the reproduction of oversized documents or documents requiring special processing, and reasonable clerical costs for locating and making the records available.]

This authorization is effective now and will remain in effect until _____ (*date*).

I understand that I may receive a copy of this authorization.

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient*

Note: To be valid, this authorization must be handwritten by the person who signs it or in typeface no smaller than 8-point type (this is 8-point type). It must be clearly separate from other language on the page and executed by a signature which serves no purpose other than to execute the authorization.

* It is unclear whether the beneficiary or personal representative of a deceased patient can obtain and disclose certain specific records, such as the patient's mental health records, and/or HIV test results.

**SAMPLE AUTHORIZATION FOR RELEASE OF MEDICAL
INFORMATION**

I hereby authorize _____, M.D., to furnish medical information concerning _____ (patient) to _____ (name and address of person to receive records).

Any and all information may be released, including, but not limited to, mental health records protected by the Lanterman-Patris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below:

_____.

The information may be used only for the following purposes:*

_____.

This authorization is effective now and will remain in effect until _____ (date).

I understand that I have the right to receive a copy of this authorization.

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship:

- parent or guardian of minor patient (to the extent minor could not have consented to the care)
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient **
- spouse or person financially responsible (where information solely for purpose of processing application for dependent health care coverage)

* Signed: _____ Dated: _____
Physician

Note: To be valid, this authorization must be handwritten by the person who signs it or in typeface no smaller than 8-point type (this is 8-point type). It must be clearly separate from other language on the page and executed by a signature which serves no purpose other than to execute the authorization.

For the release of records (1) protected by the Lanterman-Petris-Short Act (LPS) or (2) containing HIV test results, a separate authorization is required for each separate disclosure. Further, the LPS Act often requires that both the patient's treating physician and the patient, or representative, sign the authorization form before information may be released.

** It is unclear whether the beneficiary or personal representative of a deceased patient can obtain and disclose certain specific records, such as mental health records covered by the Lanterman-Petris-Short Act (*see this Chapter, section entitled "The Confidentiality of Medical Information Act and the Insurance Information and Privacy Act" question #12*) and/or HIV test results (*see this Chapter, section entitled "Special Confidentiality Requirements"*): *see also Chapter 3, "AIDS and HIV"*).

MEDICAL RECORDS: Review of Test Results

Policy

Diagnostic tests will be completed and reviewed by a clinician in a timely manner. All abnormal and stat diagnostic tests will be evaluated by a physician to determine need for follow up.

Procedure

1. All laboratory specimens sent to outside laboratories are to be logged out, with notation of patient's name, the type of test, the ordering physician, lab name and location, and date sent (MM/DD/YYYY). Staff members responsible for logging out specimen(s) will note his/her initials.
2. Panic Level results (potentially life threatening) will be reported by the lab to the practitioner **immediately**, and the practitioner will take immediate appropriate patient intervention action.
3. Written results are logged in upon receipt with date of receipt and initialed by the practitioner before being placed in the patient's chart. All test results will be required to reach the ordering practitioner for review within two (2) weeks after the completion of the test.
4. Patients will be notified by the practitioner of routine test results or changes in their treatment plan by telephone, written notice, or in person at their next office visit. Notification/intervention will be documented in the patient's chart.
5. A designated staff member will be responsible for monitoring the log. In the event the results are not returned within the expected time frame, he/she is responsible for following-up with the lab, either by telephone or fax. Follow-up calls are noted, with date and staff initials.
6. Lab tests, which require a referral for specimen collection outside of the office, are logged if the patient requires medication adjustments based on testing.
7. Orders for routine testing, associated with annual health physicals or preventive care visits, are logged only if the patient must initiate test or test follow-up.

8. Normal Test Results are initialed by a qualified clinical staff member or the physician indicating review. Patients are not customarily notified of normal test results, unless they call to request results. Patients are informed of this procedure at specimen collection.
9. Abnormal Test Results are referred to the physician for review. The physician initials results indicating review and notes action taken in the medical record (notes or on lab report itself). All patients are notified of abnormal test results and given follow-up instructions.
10. Repeated Test Results. Results for repeated tests, if indicated, follow the above procedures.

INFECTION CONTROL:

Universal Precautions, Bloodborne Pathogens Exposure, Personal Protective Equipment, Implementation, Hepatitis B Vaccination For Employees With Occupational Hazard Policy

To consider any materials that could be potentially contaminated with blood or other human body fluids as infectious and to consider all materials, instruments, environmental surfaces, etc. that could possibly be contaminated with blood or body fluids as infectious and to prevent cross contamination of infection between the following categories of persons: patients and employees, patients and patients, patients and visitors, employees and employees, and employees and visitors by the use of proper infection control techniques, appropriate use of clean/sterile supplies and equipment and providing a safe environment utilizing infection control procedures and precautions.

Procedures

1. The employer shall ensure that all procedures meet all current and appropriate regulations and recommendations and to provide training and review of all procedures as mandated by OSHA requirements for blood-borne pathogens (OSHA 29 CFR 1910.1030) and other applicable agencies. It is also the employer's responsibility to ensure that all procedures are followed.
2. The office is responsible for cleaning, laundering, disinfecting, and repairing all personal protection equipment.
3. The office provides routine housekeeping services, including the removal and disinfection of contaminated laundry and linens.
4. All employees are trained upon hire, and annually thereafter during normal working hours about the risk of exposure to blood-borne pathogens, and procedures for preventing exposure and post-exposure requirements
5. All personnel at risk for occupational exposure to blood-borne pathogens will be offered HepB vaccine and necessary boosters. Documentation of vaccine status or declination of vaccine will be maintained.

6. Determine which employee may incur exposure to blood or other potentially infectious materials.
7. List job classifications in which employees may have occupational exposure is required.
8. Provide protective equipment where there is potential for contact with contaminated sources and fluids.
9. Instruct employees that hands must be washed after direct or indirect contact with contaminated sources.
10. All personnel must wear protective gloves during procedures where contact with potentially contaminated substances is likely to occur.
11. The office supplies, at no cost to employees, personal protection equipment to all staff. Equipment includes:
 - Eye goggles and shields and face mask/shield protection.
 - Head protection, if needed. Caps for employees to restrain and protect hair,
 - Foot protection, if needed,
 - Hand protection, including latex gloves.
12. All personnel must wear protective masks during procedures when it is likely that mouth or nose may be splashed with potentially contaminated substances.
13. All personnel must wear protective eye wear during procedures when it is likely that the eyes may be splashed with potentially contaminated substances.
14. All personnel must wear protective cover gowns during procedures when it is likely that clothes will be contaminated with blood or body fluids.
15. Hands must be washed when gloves are removed or after any direct or indirect contact with any blood or body substances.
16. Potentially contaminated instruments must be handled carefully and while wearing gloves designed to withstand cleaning procedures.
17. Instruments, equipment, and environmental surfaces must be cleaned in solutions or sterilizers that are appropriate to their level of contamination and that meet appropriate guidelines.

- A critical instrument (has penetrated soft tissue or bone or come in contact with mucous membranes) 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 carefully disinfected with an intermediate or higher level EPA registered, hospital grade disinfectant. This includes, but is not limited to, equipment and environmental surfaces.

18. Appropriate use of housekeeping techniques will be implemented to prevent cross-contamination.

19. Infectious patients with communicable diseases will be managed appropriately to prevent a spread of the disease.

20. Potentially contaminated waste must be disposed of per Handling of Biohazardous Waste procedure. (Refer to that policy and procedure).

21. Blood-borne Pathogens Exposure Control Plan is as follows:

- Containers for reusable sharps
- Contaminated equipment, needles and sharps
- Exposure determination
- Hazardous and regulated waste disposal
- Hepatitis B vaccine and post-exposure evaluation and follow-up
- Housekeeping
- Implementation and compliance methods
- Information and training
- Labels and signs
- Laundry procedures
- Personal protective equipment
- Record-keeping
- Specimens
- Work area restrictions

22. A designated refrigerator should be available for medications that need to be stored in a controlled temperature environment. This refrigerator will not contain food material nor drink that is meant for patients or staff.

Refer to the Policy and Procedure in the PHARMACEUTICALS section on “Proper Maintenance and Storage of Drugs” for further information on this subject.

23. A designated area will be assigned for preparing medications and storage of clean supplies. This area will be designated as a “Clean Area” where access to any material that may or does contain any body fluids is forbidden.
24. In addition, there will be a designated area where dirty laundry, dirty supplies, used food trays and such items will be kept for further processing.
25. Hazardous/medical waste will be kept separate from regular trash. Hazardous waste can be identified as products that could contain body fluids that might transmit infectious diseases, used medical and surgical supplies that can be discarded rather than autoclaved, etc. A complete list can be obtained from state and county regulatory agencies.
 - Biohazardous waste containers are to be opened with a the step-on (no use of hands) mechanism and should be lined with a red bag liner which indicates contents are a biohazardous waste. Universal precautions should be followed with this material.
 - Waste containers with red biohazardous bags must be readily available although they do not need to be kept in every examination room.
26. Each provider shall have a specific container for disposal of used syringes and needles in compliance with state and safety regulations. Used needles will be immediately disposed of, not recapped, and placed in a puncture resistant leak proof container.
27. Outdated medications will be disposed of in a timely manner. Refer to the Policy and Procedure for Proper Maintenance and Storage of Drugs where there is a systematic review of outdated medications at least once a month.
28. A contractual agreements shall be made with a pharmaceutical disposal company in our area. The Department of Pharmacy and Health and Safety codes has standards for disposal.

29. Patient care areas will be cleaned after each patient use.
- There will be a new protector placed over the examination table. A clean strip of paper should be available for each patient. Discard used paper strips between each patient visits. This protector/barrier is placed between equipment (such as an examination table, chair, and infant weight scale) and the patient.
 - Areas contaminated with blood or infectious waste should be cleaned after contact. A 10% bleach solution is recommended.
30. Products requiring cold sterilization shall be cleaned with an appropriate solutions that will kill HIV, HBV, TB and should be used according to the product label.
- Cleaning fluid containers will be properly labeled and stored in an area controlled from patient access to avoid accidental misuse.
 - Cleaning fluid containers should be labeled with the name of the solution, the concentration, especially if dilution was indicated, the date of activation, and expiration date.

INFECTION CONTROL: Recordkeeping

Policy

The recordkeeping process is intended to allow for timely, accurate, secure, and confidential recording and use of member-specific information; and to ensure that medical records are in conformance with good professional medical practices and appropriate health management.

Procedures:

1. No medical information will be disclosed without the consent of the patient. Patients will be afforded the opportunity to consent to or deny the release of identifiable medical or other information except as required by law.
2. Medical records will be inaccessible to patients and other unauthorized persons and will be maintained to guard against unauthorized disclosure of confidential information to protect confidentiality.
3. Contracts with practitioners and providers will explicitly state expectations about the confidentiality of member information and records.
4. Each patient's medical record will be filed and stored in a central place (restricted from public access), utilizing a standardized and centralized medical group network tracking system assuring ease of retrieval, availability and accessibility as well as confidentiality.
5. Medical records will be transferred among practitioners when a member changes to a new PCP (prior to the member's first visit with the new PCP). The privacy of the medical record will be safeguarded in transit. Requested information will be delivered in a timely manner to ensure continuity of care.
6. Member medical information and records must be stored in an anonymous manner, and if disposed of, must be destroyed in such a way that information is not identifiable.
7. Each medical record will contain the following:
 - The member's name, address, date of birth, Social Security number, member and sub-subscriber identification numbers, work and home telephone numbers, emergency contact, marital status, employer, and the name of any legally authorized representative, Health questionnaire (dated and initialed by the PCP) to establish

baseline data, Immunization record, and documentation of allergies.

- A copy of a consent to treat form.
- All entries will be legible to someone other than the writer.
- Physical examinations and follow up care with appropriate subjective and objective information obtained from the presenting complaints.
- Appropriate vital signs are documented at each visit.
- Medication allergies and adverse reactions will be prominently noted in the record. If the patient has no known allergies or a history of adverse reactions, this will be appropriately noted in the record.
- Prescribed medications, including dosages and dates of initial or refill of prescriptions.
- Past medical history (for patients seen 3 or more times) is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history related to prenatal care, birth, operations, and childhood illnesses.
- For patients 13 years and older, there will be an appropriate notation concerning the use of cigarettes, alcohol, and substances (for patients seen 3 or more times, substance abuse history will be queried).
- Standardized forms for documenting prenatal care. Forms include documentation of medical, psychosocial, nutritional and educational assessments, interventions, and referrals for prenatal services (Comprehensive Prenatal Services Program [CPSP] Providers only).
- Encounter forms or notes indicating follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or as needed.
- If appropriate, a human sterilization consent form (PM330) is filed.
- Documentation of appropriate use of consultants, and if a consultation is requested, there will be a note from the consultant in the medical record.
- Consultation, lab, and imaging reports will be initialed by the physician to signify review. Consultation, abnormal lab, and imaging study results will have an explicit notation in the record for follow-up.

- Complete and current immunization records for children and adults.
 - Growth charts and documentation of neurological milestones for children.
 - Notes indicating that a patient has been referred to a specialist, a hospital, or to home health care with corresponding specialist consultant reports, discharge summary or home health reports, as applicable.
8. A member, who is receiving continuing **ambulatory** care services, (defined as three or more visits) should provide a list of important information. Such a list (often referred to as the “problem list” or “summary list”) should be in the same location as all records to help the practitioners quickly locate it. The medical record for members receiving continuing ambulatory care services must contain the following:
- A list of significant medical diagnoses, conditions, procedures, drugs,
 - Significant operative or invasive procedures,
 - Adverse and allergic drug reactions,
 - Medications prescribed for, or used by, the member.
9. Medical records for females, ages 47-47, will contain evidence that the practitioner has communicated to them their options for dealing with menopause.
10. Medical records for **diabetic** members will show (1) the medical record that contains a diabetes flow sheet, (2) the practitioner is using established diabetes practice guidelines (3) record containing annual screenings for Hemoglobin Alc, LDL-C, Microalbuminuria, and (4) record containing evidence of annual optometrist/ophthalmologist referral and reason for the referral.
11. Medical records for documented **heart disease** will show (1) records containing a problem list noting the diagnosis of hypertension, including the date of diagnosis as an entry, (2) records containing a blood pressure reading after the date of entry of the diagnosis of hypertension on the problem list, and (3) record containing evidence of a LDL-C screening performed after discharge for one of the following conditions/procedures; acute myocardial infarction, coronary artery bypass graft, and percutaneous transluminal coronary angioplasty.

12. Documentation of whether the patient has executed an Advance Directive (a written instruction such as a Living Will or Durable Power of Attorney for health care relating to the provision of health care when the individual is incapacitated) or notation that information about Advance Directives was given to the patient as required by Federal Law.

13. Adult medical records must be stored for seven years (7). Pediatric medical records must be stored until the child is 21 years of age (current State and Federal requirements).

Sample form follows.

PHARMACEUTICALS: Proper Maintenance and Storage of Drugs

Policy

To provide guidelines for the proper maintenance and storage of drugs in the physician's office. To assure that each facility has an established process to monitor the expiration dates of drugs, proper storage of drugs, insure proper labeling of drugs, secure the safety of the drugs, and to ensure proper disposal and documentation of drugs.

Procedure

1. Each provider will have a procedure in place to assure that all medications are current, dates have not expired, and sample medications are listed and current.
 - The expiration date of all medications will be checked, monthly. To assure this process has been followed, a chart of medications will be maintained with the inspector's initials and date.
 - A sample chart is attached that can be utilized for this purpose.
2. Each provider will have a procedure in place to assure that all medications are properly labeled.
 - The labeling will include the following:
 - Name of drug,
 - Concentration,
 - Route of administration (topical, oral, parenteral, etc.).
 - Storage information such as the temperature and light requirements
 - A sample is attached for clarity
3. Drugs are accessible only to authorized office personnel and are kept in a locked cabinet or drawer. This includes sample medications that are to be maintained in a secure manner.
4. It is recommended that internal and external drugs be stored separately to avoid drug administration errors.
5. Medications that require refrigeration will be maintained at 35° - 46° "F" or 2-8° "C". Freezer shall be maintained at 7° "F" or -14° "C".
 - Purchase a thermometer specific for this use.

- A daily temperature log is recommended for each work day with the employee's initials on the form.
 - Varicella must be stored at 5° "F" or -1.5° "C".
 - A sample chart is attached as a suggested resource.
6. Medications must be prepared in a clean area such as an area free of body fluids or dirty equipment such as food trays, urinals, dirty linen, and the like. You may refer to the Policy and Procedure "Infection Control" for recommended cleaning agents.
 7. Needles and syringes must be stored securely in a locked container. It is also important that they be kept in an area where patients do not have access.
 8. All controlled drugs are to be stored in a securely locked cabinet. Current inventory is to be maintained on each controlled substance. The physician is ultimately responsible. The DEA must be current.
 9. Drugs are to be dispensed by the physician and mid-level practitioner. A mid-level practitioner is a medical assistant, a Licensed or Registered Nurse, Nurse midwife, Nurse Practitioner, or Physicians Assistant. Drugs will be dispensed by providers to their own patients. The provider will not sell sample medications. Medications will be properly labeled.
 10. An appropriate record will be entered in the patient's chart referring to those drugs prescribed and dispensed. Sample medications also must be recorded in the patient's medical record.
 11. The Poison Center telephone number should be accessible in a prominent location. The Poison Center can be utilized for poisoning emergencies, drug consultation, drug interactions, foreign and national drug identification to name a few of their services. You may obtain literature and telephone stickers by contacting them.

OTHER: Members Rights and Responsibilities

Policy

To ensure that members receive quality care that is professionally delivered in a manner that respects their rights.

Procedure

1. Members have a right to:
 - Receive information about services, practitioners, and providers.
 - Be treated with respect in recognition of their dignity and right to privacy.
 - Participate with practitioners in decision making regarding their health care.
 - A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
 - Voice complaints or appeals about their care.
 - Be represented by parents, guardians, family members or other conservators when the members are unable to fully participate in their treatment decisions.
 - Discuss potential treatment options (without regard to plan coverage), side effects of treatment, and management of symptoms. Practitioners will be expected to educate members regarding their health needs and share findings of history and physical examinations.
 - Make the final determination in the course of action among clinically acceptable choices.

2. **Members** have the responsibility to:
 - Provide, to the extent possible, information that its practitioners/providers need in order to care for them.
 - Follow the plans and instructions for care that they have agreed on with their practitioners.

3. **Practitioners/providers** have the responsibility to:
 - Provide services in a culturally competent/non-discriminatory manner to all members, including those with limited English proficiency or reading skills (i.e., translator and interpreter services), and those with diverse cultural or ethnic backgrounds.

- Provide information that is readable, easily understood (at 8th grade level), consumer tested and as needed, in the languages of the major population groups served. If 10% of the population speaks a language other than English, member materials should be provided in that language.
- Make public declarations (i.e., via posters, member handbooks, newsletters or mission statement) that provision of health services is not influenced by member's race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.
- Provide members with information needed to understand benefit coverage and obtain primary and specialty care.
- Provide its members, upon request, with information about prior authorization rules.
- Provide written information to the member about how to voice a complaint. All member complaints, grievances, and appeals will be referred to the Health Plan.