SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

ITEM
2.2
(ID # 6748)

MEETING DATE:
Tuesday, April 3, 2018

FROM : RUHS-MEDICAL CENTER:

SUBJECT: RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER: Approve Policies

RECOMMENDED MOTION: That the Board of Supervisors, acting as the Riverside University Health System-Medical Center (RUHS-MC) Governing Board:

1. Review and approve the attached Medical Center and Clinics Policies.

ACTION: Policy

Jennifer Cruikshank, Chief Executive Officer – Health System 3/28/2018

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Perez, seconded by Supervisor Jeffries and duly carried, IT WAS ORDERED that the above matter is approved as recommended.

Ayes:	Jeffries, Washington and Perez
Nays:	None
Absent:	Tavaglione and Ashley
Date:	April 3, 2018
xc:	RUHS

Kecia Harper-Ihem
Clerk of the Board
By: _____ Deputy

SUBMITTAL TO THE BOARD OF SUPERVISORS COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost:
COST	$ 0	$ 0	$ 0	$ 0
NET COUNTY COST	$ 0	$ 0	$ 0	$ 0
SOURCE OF FUNDS: N/A			Budget Adjustment: No	
			For Fiscal Year: 17/18	

C.E.O. RECOMMENDATION: Approve

BACKGROUND:

Summary

The Riverside University Health System Medical Center (RUHS MC) is a licensed and accredited acute care hospital serving the needs of County residents since 1893. RUHS MC currently has two campuses – one in Moreno Valley and one off County Farm Road in the City of Riverside.

As an acute care hospital RUHS MC is required by the State of California to have a "governing body" separate from its administrative leaders and medical staff leadership. The "governing body" is "the person, persons, board of trustees, directors or other body in whom the final authority and responsibility is vested for conduct of the hospital." 22 CCR §70035. (See also 42 CFR 482.12 and Joint Commission Standard LD.01.03.01) The Board of Supervisors serves as the "governing body" for the hospital.

Various regulatory requirements mandate that the Governing Board participate in the leadership and decision-making of the Medical Center by reviewing and approving its policies relating to certain topics. The attached policies relate to:

- Incident Reporting
- Access to Language Services for Limited English Proficient, Deaf, and Hearing Impaired Persons
- Practitioner Notification and Accountability of Inpatient Incomplete and/or Delinquent Records
- Financial Assistance Programs
- Patient Medical Records
- Mental Health Patient Rights
- Disclosure of Unexpected Outcomes
- Patient Informed Consent
- Abuse, Neglect, and Domestic Violence Reporting
- Restraints and Seclusion
- The Federal Emergency Medical Treatment and Active Labor Act: EMTALA
- Notification of Privacy Breaches

- Transportation of Protected Health Information
- Medication Orders
- 340B Program Compliance

Impact on Residents and Businesses

In 2017 RUHS MC provided care to residents of the County and others in more than 19,000 inpatient stays and more than 230,000 emergency and outpatient encounters. As part of its operations it employs more than 3,000 individuals and contracts with over 1,000 other individuals and businesses. An efficient, well-functioning medical center providing care of high quality creates many positive benefits for Riverside County citizens and its businesses.

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 122	Page 1 of 6
Title: Incident Reporting	**Effective Date:** 5/22/2017	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Zareh Sarrafian, CEO/ Hospital Director		☐ Policy ☒ Procedure ☐ Guideline

1. DEFINITIONS

1.1 Incident- is defined as any unusual event or circumstance, occurrence, or emergency, involving a hospital patient, visitor, or staff member, that is not consistent with the routine operation of Riverside University Health Systems (RUHS) - Medical Center and its staff. Incidents include, but are not limited to:

a. Sentinel events subject to review by The Joint Commission.

b. Unusual occurrences subject to review by the California Department of Public Health (CDPH).

c. Adverse events pursuant to the Health and Safety Code (HSC) Section 1279.1

d. Adverse drug events as reported to the Food and Drug Administration's (FDA) MedWatch program.

1.2 Sentinel Event- is defined by The Joint Commission, Comprehensive Accreditation Manual for Hospitals (CAMH) as:

a. An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

b. The terms "sentinel event" and "error" are not synonymous; not all sentinel events occur because of an error, and not all errors result in sentinel events.

c. See Resources and Links in the "Incident Report Help" found on RUHS- Medical Center Intranet, under the Clinical Services tab, for Definitions of Occurrences Subject to Review by The Joint Commission.

1.3 Unusual occurrence- is defined by California Department of Public Health, Title 22, California Code of Regulations, Sections 70737 and 71535, as:

a. A serious event that could seriously compromise quality or patient safety.

b. See Resources and Links in the "Incident Report Help" found on RUHS- Medical Center Intranet, under the Clinical Services tab for Examples of Incidents that Require Completing an Incident Report

1.4 Adverse event- is defined by the California Health and Safety Code (H&SC 1279.1) as:

a. An event that causes the death or serious disability of a patient, personnel, or visitor.

b. See Resources and Links in the "Incident Report Help" found on RUHS- Medical Center Intranet, under the Clinical Services tab, for Reportable Adverse Events

(H&SC Section 1279.1), which lists the 28 enumerated occurrences that could negatively impact patient care and safety.

1.5 Adverse Drug Event (ADE)- is defined as an injury and/or harm caused to an individual from the use of a drug due to, but not limited to:

a. Adverse drug reactions and overdoses,
b. Dose reductions and discontinuations of drug therapy,
c. Medication errors.

1.6 Serious Disability- is defined as a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven (7) days or is still present at the time of discharge from an inpatient healthcare facility, or the loss of a body part.

1.7 Incident Report- is defined as a confidential communication to the Quality Management Department and hospital department managers. The report:

a. Is completed for all sentinel events, unusual occurrences, adverse events, and adverse drug events.
b. Documents facts; assists in evaluating cause and contributing factors; and provides recommendations for mitigating future incidents.

2. RESPONSIBILITIES

2.1 Hospital Administration:

a. Shall ensure compliance to this procedure.
b. Shall ensure that appropriate reporting requirements are met.
c. Shall be responsible for reporting to regulatory bodies when required.
d. Or designee must ensure that the patient or patient representative is informed about the incident, when appropriate.

2.2 Hospital staff witnessing and/or involved with an incident involving a hospital patient, visitor, or staff member shall be responsible for:

a. Taking immediate steps to protect the patient, visitor, and/or staff's safety.
b. Immediately reporting the incident to the department management or designee.
c. Providing a verbal account of the incident to the patient's physician or designee.
d. Submit an online Incident Report.

2.3 Department Management shall:

a. If not already done by staff, take immediate steps to protect patient, visitors, and staff's safety.
b. Immediately report the incident by phone or in person to the respective Hospital Administration personnel.
c. If not already done by staff, notify the patient's physician and preserve any evidence that may be useful in the investigation of the incident, such as I.V. bags and tubing, medication vials, and/or medical equipment.
d. Remove from service any defective equipment that may have contributed to the condition. Place a "Stop Do Not Use" tag on the defective equipment and secure it in a locked area for further investigation.
e. Assure the online Incident Report is submitted.

2.4 The Quality Management Department shall:

a. Provide quarterly trending reports to the hospital Performance Improvement Patient Safety Committee.
b. Monitor the timeliness, completeness of investigation and response, and accuracy of harm scores.
c. Ensure appropriate referrals have been made to department heads and medical staff departments, as needed, for additional information/investigation and feedback response.
d. Maintain Incident Reports and any attachments on the Quality Management (QM) servers purchased for this purpose.
e. Provide necessary information to County Risk Management.

2.5 The Information Services Department shall:

a. Maintain the QM Department servers and Structured Query Language (SQL) software.
b. Backup the QM Department servers and SQL software/ application data daily.
c. Provide technical support and troubleshooting of servers, software, and access.
d. Grant appropriate access to the Incident Report software application through Active Directory. All RUHS- Medical Center staff shall have access to enter an Incident Report without requiring a password.
e. Management level access for entering investigations and providing responses, making referrals to other departments, and running their department-specific reports shall be approved by the Quality Management Department before access is granted through Active Directory.

2.6 The Performance Improvement and Patient Safety Committee (PIPSC) shall:

a. Aggregated data from Incident Reports are analyzed by the Quality Management Department, as well as hospital department managers and directors, and are used in Performance Improvement/Patient Safety programs to identify trends, to improve systems and processes, and to mitigate future risk/ harm.

2.7 The Safety Office shall:

a. Review and do follow up on visitor and staff Incident Reports.

3. PROCEDURES

3.1 Completing an Incident Report.

a. After the discovery of an incident, staff members with knowledge of the incident must submit an Incident Report online.
b. Every effort must be made to complete and enter an Incident Report within 2 business days of the incident.

3.2 Accessing the Online Incident Reporting System.

a. Access the Online Incident Reporting system via the desktop icon labeled Datix Incident Reporting or log on to the RUHS- Medical Center Intranet page.
b. On the RUHS-Medical Center Intranet page, click on the Clinical Service tab, then click the Incident Reporting tab.
c. Once in the Incident Reporting page, click on http://datixapp01/datix/live/index.php. A password is not needed to enter an Incident Report.
d. The system will shut down after 10 minutes of inactivity and any information entered will be lost.
e. Questions with a red asterisk are required and you cannot move to the next tab until these are completed.

f. Quality Management staff
review all Online Incident Reports. Based upon the review, consultations and/or referrals may be sent to additional Department Management and/or Department Chairs.

3.3 Management/ Department Chair Review & Investigation of Incident Reports

a. If an Incident Report is submitted related to a staff injury, the required paperwork for Workers' Compensation First Report of Injury or Illness form(s) must still be completed and forwarded to Occupational Health Department.

b. The RUHS-Medical Center Performance Management Decision Guide is a resource to help determine system issues and performance issues. It is available on the "Incident Report Help" link from the RUHS- Medical Center Intranet.

c. For harm scores of 7, 8.or 9, the manager must read the report immediately and document the manager review within 2 business days from the date the report was filed.

d. For harm scores 1-6 the manager must read the report and complete the manager review within 10 business days from the date the report was filed. An additional 10 business days is allowed for secondary manager(s) investigation and response.

e. In case of the manager's absence, the manager should delegate the incident response documentation to an alternate designee. If the designee does not have access to UHC Safety Intelligence, contact the QM Department.

f. All RUHS- Medical Center UHC Safety Intelligence Incident Reports will be investigated, responded to, and closed within 30 business days. Quality Management may keep the report open for longer than 30 business days, as needed.

3.4 Access to UHC Safety Intelligence Reports

a. UHC Safety Intelligence access is provided to management, and Department Chairs, and their alternates.

b. An Information Services (IS) System Access Request (SAR) must be completed and approved by the QM Management.

c. The QM Department will submit the approved SAR to IS for granting the access.

d. Training with QM Department will occur after access is granted.

3.5 General Considerations

a. Do not copy and paste a UHC Safety Intelligence Incident Report into an email. Use the consultation function to send an Incident Report to a person who has access to the system. Please refer to the "Incident Report Help" resource link for consultation instructions if needed.

b. Do not print Incident Reports. If printing is unavoidable, keep the report confidential and shred it immediately after use.

c. When sending an email, do not put the incident number nor any patient identifiers in the subject line. The UHC Safety Intelligence incident number may be used in only in the body of the email message.

d. The automated notification will include the Safety Intelligence number in the subject line, without patient information in the subject line or the body of the email.

e. Do NOT put a copy of the Incident Report, or any part thereof, in the patient's chart.

f. Completed Incident Reports must never be filed in any department except the Quality Management Department.

g. Do NOT write anything in the patient's medical record that an Incident Report has been filed. The patient's medical record should reflect only the facts of the Incident and outcome as required for patient care.

h. Do NOT leave the Incident Report screen open when not in use where could be viewed by others.

i. Incident Reports are not to be used for employee discipline. Appropriate personnel procedures must be followed in addition to completing the Incident Report form.

j. The RUHS- Medical Center Performance Management Decision Guide is an algorithm that identifies a "Just Culture" decision tree to assist in the "Manager Review"

4. RESOURCES AND LINKS

4.1 "Incident Report Help" found on RUHS- Medical Center Intranet, under the Clinical Services tab. Click on the Incident Reporting tab and to the right is the IR Help tab, is available to all RUHS- Medical Center staff. Resources include but are not limited to:

a. Event Type Reference Guide

b. Quick Reference Guides for:

- Front line reporters,
- For management investigations

c. RUHS- Medical Center Performance Management Decision Guide

d. Incident Reporting Electronic System Process Flow

e. Definitions of Occurrences Subject to Review by The Joint Commission (CAMH SE1-2, Update 2, January 2017)

f. Examples of Incidents that Require Completing an Incident Report

g. Reportable Adverse Events (H&SC Section 1279.1)

5. REFERENCE

5.1 RUHS- Medical Center Policy No. 630, Behavioral Restraint or Seclusion Use for the Violent or Self- Destructive Patient

5.2 RUHS-Medical Center Policy No. 654, Sentinel Event

5.3 RUHS-Medical Center Policy No. 805, Medication Errors and Adverse Drug Reactions

5.4 RUHS-Medical Center Policy No. 555, Reporting Broken Equipment

5.5 RUHS-Medical Center Policy No. 511 Code Pink – Infant/child Abduction

Document History:

Release Dates: 5/1982, 3/2000, 6/2005, 11/2008, 5/2012, 8/2013	**Retire Date:** N/A
Document Owner: Quality Management	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made?	Revision Description
8/24/2016, 2/8/2017, 2/9/2017, 3.29.2017	Quality Management	Yes	RCRMC changed to RUHS throughout policy. Section 3.3 Department managers changed to Department Management. Section 4. 4.1 CMO/CNO/Patient Safety Officer/AHA/ACNO and Quality Management Director changed to Hospital Administration. Section 4, 4.1, a. AHA/ACNO and Patient Safety Officer, Chief Operating Officer, Chief Nursing Officer, Chief Medical Officer changed to Hospital Administration. Policy 511 and 626 referenced- but outdated. Are they in review? Removed Policy # 601.6- no longer active. All CAMH manual references updated to reflect the current CAMH manual. 4.2 Added additional access via desktop icon. Flow charts and attachments removed and identified as being found on SharePoint link.
9/1/2016	Information Services	No	
3/20/17	Nursing	Yes	Page 2, 3.1.d added "when appropriate" at the end of the sentence. Added 4.13.i regarding "Just culture"
3/20/17	Legal	Yes	Can add a reference to evidence code 1157 Added 2.3
3/1/17	Administration	No	Discussed with A. Simpkins. To be reviewed at HEC
4/7/2017	Regulatory compliance	No	
5/7/201	Policy Approval Committee	No	
5/22/2017	Hospital Executive Committee	No	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

HOUSEWIDE

	Document No: 142	Page 1 of 8
Title: Access to Language Services for Non or Limited English Proficient, Deaf, and Hearing Impaired Persons	**Effective Date:** 2/15/2017	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Zareh Sarrafian, CEO/ Hospital Director		☐ Policy ☒ Procedure ☐ Guideline

1. DEFINITIONS

1.1 Medical/Healthcare Interpreter: An individual who (1) has been trained in healthcare interpreting, (2) adheres to the professional code of ethics and protocols of medical interpreters, (3) is knowledgeable about medical terminology, and (4) can accurately and completely render communication from one language to another. All Medical Interpreters have been tested for fluency in the languages in which they interpret and will, ideally, be accredited by a nationally recognized organization for the certification of medical/healthcare interpreters.

1.2 Health Care Interpreter Network (HCIN): A network of public hospitals located nationwide that share their pool of professional healthcare interpreters through remote audio and video technology. The HCIN system is available 24 hours a day, 365 days a year by dialing micro 6-5602 from the Medical Center and Arlington Campuses, and either extension 6-5834 from the Federally Qualified Health Centers or 486-5834 if using a cordless interpreter phone at these locations.

1.3 Interpreting: The immediate oral conveyance of words spoken or signed in one language into comparable meaning in a target language and vice versa for the purpose of facilitating the exchange of communication between two or more persons speaking different languages.

1.4 Limited English Proficiency (LEP): Refers to the limited ability or inability of an individual to speak, read, write, or understand the English language at a level that would permit the individual to effectively participate in his/her healthcare.

1.5 Preferred Language: Refers to the language identified by the patient and/or patient representative as the language of choice for all communications with providers of primary and ancillary medical care, as well as auxiliary and administrative hospital services.

1.6 Simultaneous Interpretation: The speaker's voice is interpreted at the same time he or she is speaking, with minimal delay. Simultaneous interpretation in conference and/or large group meeting settings requires interpreters skilled in this mode of interpretation and the use of special simultaneous interpreting equipment. The interpreter conveys the message into another language, speaking into a microphone connected to a wireless transmitter. Through the use of headsets connected to wireless receivers, meeting attendees listen to the interpreter's rendition of the event in their preferred language.

1.7 Telecommunications Device for the Deaf (TDD): The TDD is a teleprinting device used in conjunction with an analog telephone line. Much like a typewriter, this device enables deaf patients to type a message on the keyboard, which is then transmitted

through the phone line to a compatible receiving device. Written messages may also be converted to voice messages via a relay operator.

1.8 Telephone (or Telephonic) Interpretation: A form of remote interpreting that offers the delivery of interpreter services through telephone technology. The interpreter is at a different physical location than the patient/physician encounter. Telephone interpreting involves an audio connection between the patient, physician (or other hospital personnel) and interpreter. Telephone interpreting is best conducted with auxiliary telephone equipment such as a dual headset or speakerphone to allow for the most effective communication among the three parties.

1.9 Threshold Languages: The preferred languages of a substantial number of the LEP patient population as defined by existing law. RUHS-Medical Center follows all required local, state, and federal regulations of governing bodies in regards to language needs.

1.10 Translation: The process of transferring written words or text from one source language into another target language, also in written form, with attention to accuracy, appropriate literacy level, and cultural sensitivity, while maintaining the same meaning and context as the original document.

1.11 Video Interpretation: A form of remote interpreting that offers the delivery of interpreter services through videoconferencing technology. In this format, the interpreter is at a different physical location than the patient/physician encounter. Videoconferencing units show a visual image of the patient and provider to the interpreter and a visual image of the interpreter to the patient and provider, along with an audio connection of their exchange.

1.12 Video Relay Service (VRS): A form of Telecommunications Relay Service (TRS) that enables persons with hearing disabilities who communicate in American Sign Language (ASL) to connect with voice telephone users through video equipment, rather than through typed text. Video equipment links the VRS user with a TRS operator – called a "communications assistant" (CA) – so that the VRS user and the CA can see and communicate with each other in signed conversation (Federal Communications Commission). Deaf or hard of hearing patients may use the VRS device to directly communicate with friends and family who have compatible video devices or computer applications.

1.13 Threshold Languages: Threshold Languages are those which are spoken at a high proportional rate within a geographic region and as such may contribute to obstacles of understanding and access for those seeking mental health services. A threshold language is defined by California as one that has been identified as the primary language, as indicated on the Medi-Cal Enrollment Data System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.

2. PROCEDURES

2.1 Informing Patients of Their Right to Interpreting Services

a. At no time, shall a provider of service require nor request a patient, family member, or patient representative provide their own interpreter.

b. RUHS-Medical Center will develop and post in high traffic patient and visitor locations notices that advise patients and their families of:

- The availability of language interpretation services at no charge.

- The telephone numbers, including a TDD number for the hearing impaired, where complaints may be filed concerning language access or interpreting issues.

c. At a minimum, notices will be posted in the following areas:

- Emergency Department
- Admitting area
- Hospital entrances
- Outpatient areas.
- Patient guide books
- Hospital website

2.2 Identification and Documentation of Language Needs

a. Patients will be asked their preferred language of communication at time of registration and/or admission.

b. Documentation of language preference and/or need will be made on the face sheet and noted in the patient's medical record by corresponding admission or registration staff.

c. If the patient is a minor, is incapacitated, or has a designated representative, the language preference of the parent, guardian, or representative will be documented.

2.3 Use of Appropriate Interpretation Services for LEP, Deaf, or Hearing Impaired Patients or their family members

The appropriate mode for the rendering of interpreting services will be determined upon consideration of the type of interpreting service available for the language required, reasonable timeliness in obtaining the service, a department's technical capacity for phone/video interpretation, and patient preference.

Available modes of interpreting services include:

a. In-person interpreting from a professional medical interpreter or qualified bilingual staff member (See section 3.1 for interpreter qualifications.)

- In-person interpreter services are available for Spanish, American Sign Language, and other languages as interpreter positions are vacated and/or filled. In-person interpreting services may be obtained by contacting the Department of Language and Cultural Services at extension 64320 during office hours.
- Simultaneous interpretation services for conferences, meetings, and group events are available from the Department of Language and Cultural Services in Spanish, American Sign Language, and possibly other languages. The department relies on the use of special wireless equipment for the provision of this service in up to two (2) non-English languages per event plus direct connect to conference/group speakers for hearing assistance by hearing impaired attendees. This service may be arranged through the Department of Language and Cultural Services with a minimum of 72 hours' notice prior to the event.

b. Telephonic interpreters via the HealthCare Interpreter Network or RUHS–Medical Center's contracted language service provider.

- Telephonic interpreters may be reached by dialing extension 65602 from any hospital phone at the Medical Center or Arlington campuses. Staff from the Federally Qualified Health Centers are to call extension 65834 from office phones or dial 486-5834 from cordless interpreter phones.
- In the event of technical failure, the commercial language service provider may be reached directly by calling (866) 874-3972. The hospital identification code is 501608; the cost center number/ access code varies per location and is noted on the equipment. Codes may be provided by the unit or department manager and/or by the Department of Language and Cultural Services.

c. Video interpreters via the HealthCare Interpreter Network.

- Video interpreting units are available on a check-out basis from the Department of Language and Cultural Services. The department may be contacted during office hours for delivery and set-up of the units; for after hours, the House Supervisor may be called for assistance. Instructions for use are posted on all video interpreting units and in the Language and Cultural Services portal of RUHS–Medical Center's intranet website.

***Note**: With the exception of emergency situations, RUHS-Medical Center providers will not use family members, friends, or unqualified interpreters in any clinical encounter except as noted in section 2.4. **The use of minor children as interpreters is not allowed** in any clinical situation at RUHS–Medical Center save for emergency situations or when interpreting services in the required language are not available after all viable resources have been exhausted. Necessary emergency care is not to be withheld pending the arrival of interpreter services.*

2.4 **Available Interpreting Services Declined: Patient Preference for Personal Interpreter**

Should the patient/patient representative insist on having a family member or friend interpret during a clinical encounter, hospital staff shall:

a. Ensure that the patient understands that interpreting services are legally guaranteed and free of charge;

b. Document in the patient's chart the offer of interpreting services and the patient's declination;

c. Obtain the services of a qualified medical interpreter to remain on stand-by/ listening mode in conjunction with the family member or friend in order to ensure accuracy and effective communication during the encounter; and

d. Document the presence of the stand-by interpreter in the patient's chart.

2.5 **Translation Services**

Translation requires human expertise; therefore, to ensure the accuracy, proper linguistic register, and cultural sensitivity of all translated materials at RUHS – Medical Center, all written translations in the Spanish-English language pair will be performed by appropriately credentialed translators from the Department of Language and Cultural Services. For the translation of documents involving another language pair, the Department of Language and Cultural Services will arrange for translation through a contracted language service provider. The use of automatic

machine translation tools or computer applications such as Google Translate is prohibited due to their limitations regarding accuracy and content management.

a. All patient information material, vital documents, and signage required by State and Federal law will be translated into all threshold languages.

b. All departments requesting written translations may submit the final and approved English document to the Department of Language and Cultural Services for translation and project management. Documents are to be submitted in electronic format whenever possible and appropriate.

c. All forms to be filed in the patient's medical record must obtain approval from the Medical Records Forms Committee prior to being submitted to the Department of Language and Cultural Services for translation.

d. No written translations from web sites or other institutions will be adopted for RUHS – Medical Center use unless the above standards for the translation process have been utilized and copyright approval has been obtained or if the form in question is from a state or federal agency that does not allow translation of standardized forms due to legal purposes.

e. Vital Documents may include but are not limited to the following:

- Informed Consents
- Advanced Directives
- Grievance and complaint forms
- Intake forms with potential for important health consequences
- Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal
- Notices advising Limited English Proficient (LEP) persons of free language assistance, or applications to participate in a program or activity or to receive benefits or services.

3. GUIDELINES

3.1 Interpreter Qualifications

Qualified providers of healthcare interpreting services at RUHS – Medical Center include:

a. RUHS – Medical Center designated employees who are certified as professional medical interpreters and work in the Department of Language and Cultural Services.

b. Bilingual hospital staff members provided they meet the following qualifications:

- Passed the County of Riverside Bilingual Assessment test with results documented by Human Resources; **AND**
- Completed the Interpreting Skills Workshop offered by the Department of Language and Cultural Services **prior** to providing interpreting services.

c. Bilingual Physicians

Given their extensive knowledge of specialized terminology, bilingual providers may communicate directly with their patients without the use of an interpreter, and/or may interpret for other providers in the fulfillment of their duties, should they meet either of the following criteria:

- The provider is a native speaker of the LEP patient's native or preferred language of communication.
- The provider is not a native speaker but has received his/her medical training in the same language as the patient's native or preferred language of communication.

3.2 Limitations to Performing Interpreting Services

a. Self-identification as bilingual is not sufficient to ensure effective communication. Bilingual staff fluent in a language other than English may be able to converse in that language but may not have the ability and/or skills required to accurately transfer messages into another language.

b. Except as noted in 4.1.c., bilingual staff members who have not completed the Interpreting Skills Workshop should only perform interpreting services in emergency situations when no qualified interpreter is available.

c. If any bilingual staff member communicating directly with a patient determines that regionalisms or cultural differences pose a barrier to effective communication, a professional interpreter must be called.

3.3 Telecommunication Devices for the Deaf and Hearing Impaired

Telecommunication Devices for the deaf and hearing impaired are available upon request of patients, family members or patient representatives. Available devices include:

a. Video Relay Service Units may be checked out from the Department of Language and Cultural Services at RUHS – Medical Center Moreno Valley and Arlington Campuses during office hours. The House Supervisor my retrieve the VRS devices after office hours.

b. TDD devices are available from the Communications Department at RUHS – Medical Center Moreno Valley Campus and in Units B and C at the Arlington Campus.

c. Instructions for use of telecommunication devices for the deaf are available in the Language and Cultural Services webpage located in RUHS-Medical Center's intranet portal.

d. For participants of conference/group events that require hearing assistance, special wireless receivers are available by contacting the Department of Language and Cultural Services.

3.4 Reasonable Time

a. Access to language services is available almost instantly via phone and video through RUHS–Medical Center's remote interpreting services.

b. Should the patient/patient representative decline the use of RUHS–Medical Center's remote interpreting services, or the language required not readily be

available through RUHS–Medical Center, the HCIN, or RUHS–Medical Center's contracted third party for remote interpreting services, the timeline for the provision of interpreting services will be as stated in the contract agreement between RUHS–Medical Center and the respective language services agency and dependent upon said agency's ability to locate and assign an interpreter in the required language.

c. For all conditions indicating clinical urgency for the provision of medical services, RUHS–Medical Center will make every effort to acquire interpreting services within a reasonable time or as close to the same time as the provision of medical services.

4. REFERENCES

4.1 California Government Code, §§7290-7295, referred to as the Dymally-Alatorre Bilingual Services Act

4.2 California Health & Safety Code, §1259

4.3 Centers for Medicaid and Medicare Services Centers, Interpretive Guidelines for 42 CFR §482.13 Condition of Participation: Patient's Rights (Rev. November, 2015). Available at https://www.cms.gov

4.4 Department of Health & Human Services, 45 CFR §80.3(b)(2)

4.5 Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency"

4.6 Patient Protection and Affordable Care Act, §1557

4.7 Rehabilitation Act of 1973, §504(F)

4.8 Straight Talk: Model Hospital Policies & Procedures for Language Access. California Health Care Safety Net Institute (2005). Available at http://www.safetynetinstitute.org

4.9 The Joint Commission Comprehensive Accreditation Manual for Hospitals, Update 2, September 2012, Standard RI.01.01.03

4.10 Titles II and III of the Americans with Disabilities Act, Revised Regulations, 2010

4.11 Title VI of the Civil Rights Act of 1964

4.12 U.S Department of Health & Human Services, Office of Minority Health, National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice (April, 2013). Available at www.thinkculturalhealth.hhs.gov

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2/15/2017	Hospital Executive Committee		

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

	Document No: 150	Page 1 of 5
Title: Practitioner Notification and Accountability of Inpatient Incomplete and/or Delinquent Records	**Effective Date:** 5/22/2017	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Zareh Sarrafian CEO / Hospital Director		☐ Policy ☒ Procedure ☐ Guideline

1. PURPOSE

1.1 To define how record deficiencies are to be assigned and practitioners informed of said deficiencies.

1.2 To specify the conditions under which reasonable and appropriate sanctions may be taken by the Medical Staff for failure to complete medical records as required, the nature of the sanctions available for use, the restrictions to be observed in using these sanctions, and the method of implementation.

1.3 To establish policy and procedure for corrective action when a member of the Medical Staff, including Allied Health Professionals, has become delinquent in completion of medical records.

2. DEFINITIONS:

2.1 Incomplete: A medical record (documented/dictated, authenticated), that has not been completed by the practitioner within the specific timeframe but certainly no later than 14 days of patient's discharge.

2.2 Delinquent: A medical record (documented/dictated, authenticated), that has not been completed by the practitioner 14 days post the patient's discharge.

2.3 Suspension: Physician's admitting and surgical/procedure scheduling privileges are temporarily suspended until all medical records are completed.

3. REGULATORY REQUIREMENTS:

3.1 Title 22, California Administrative Code, Section 70751 (g), requires that the medical records shall be completed promptly and authenticated or signed by a licensed healthcare practitioner acting within the scope of his or her professional licensure within two weeks following the patient's discharge.

3.2 42 CFR Part 482.24(b)(c) Condition of Participation states that medical records must be accurately written, and promptly completed after discharge in accordance with State laws and hospital policy but no later than 30 days after discharge.

3.3 The Bylaws, Rules and Regulations of the Medical Staff: The Medical Record requires the patient's medical record to be completed within 14 days of discharge by the Attending Physician or Allied Health Professional. An operative or invasive procedure report must be completed immediately following the procedure. If a

practitioner fails to complete medical records on a timely basis, the President of the Medical Staff/Medical Director or designee, may suspend the practitioner's admitting, operating, and consultation privileges, and/or enforce other pertinent contractual stipulations.

3.4 The Joint Commission, Standard RC. 01.01.01 requires the hospital maintains complete, accurate and authenticated medical records for each individual patient. Documentation in the medical record must be entered in a timely manner, not to exceed 30 days after the patient's discharge.

4. PROCEDURE

4.1 Medical records are expected to be completed in accordance with hospital policy to facilitate care coordination.

4.2 All types of medical records, except ambulatory clinic and ambulatory procedure notes, will be included in this policy.

4.3 Members of the Medical Staff (including Allied Health Professionals) shall be responsible for completion of the medical record.

4.4 House staff physicians, including interns and resident physicians, operating within their scope of practice, may complete and sign a History and Physical (H&P), operative report, brief operative note, progress note, labor & delivery note, ED note, and discharge summary. These medical records must be authenticated and co-signed by the supervising Medical Staff member within 14 days from the date of discharge.

4.5 Medical record completion:

a. H&P shall be completed through the EPIC template, dictated, or on paper (during downtime) no more than 30 days before or 24 hours after admission, but prior to surgery or a procedure requiring anesthesia services.

b. A brief operative note or operative report shall be completed immediately after surgery. A complete operative report shall be dictated or completed through the EPIC template within 24 hours after surgery.

c. Progress notes, labor & delivery notes, ED notes, and discharge summaries shall be completed through the EPIC template, dictated, or on paper (during downtime), and authenticated and signed within 14 days from the date of discharge. All deaths require a death summary completed in EPIC or dictated.

4.6 Members of the Medical Staff (including Allied Health Professionals) shall receive notification from the Health Information Management (HIM) Department of medical records deficiencies prior to the time the records will be considered delinquent.

4.7 If at any time the practitioner contests the incomplete or delinquent medical record, it is the responsibility of the practitioner to contact the HIM Department promptly. HIM representatives will investigate the practitioners claim(s), taking into consideration any mitigating circumstances, and make a final determination. The timeline for pending suspension of the provider will be stopped until such determination is made.

4.8 When a provider is identified as out of compliance with respect to completion of medical records the enforcement process will proceed as follows:

a. Non-operative medical records (including progress notes, ED provider notes, procedure notes, and discharge summaries):

   i. **Time = 0**: The provider is identified by HIM as having an incomplete medical record if not completed after the point of care. No specific notification of the provider is provided beyond flagging the electronic medical record (within EPIC in-basket).

   ii. **Time = Eleven (11)** days after the provider is identified as having an incomplete medical record, HIM will evaluate the medical record to confirm responsibility and, if appropriate, will notify the provider via email, pager, text messaging or phone call, of the delinquent medical record(s). HIM will also contact the Department Secretary via phone call, who will then make person-to-person contact with the provider of the pending suspension of privileges if the medical record is not completed in next 3 days.

   iii. **Time = Fourteen (14) days** after the provider is identified as non-compliant with medical records completion, HIM will evaluate the medical record to confirm responsibility and, if appropriate, will establish person-to-person contact with the provider via email, pager, text messaging or phone call, as well as the Department Secretary via phone call, to inform them of the delinquent medical record and imminent suspension of privileges. HIM will also notify Medical Staff Administration (MSA) that privileges should be suspended. The MSA will contact the provider's Department Secretary and Department Chair (and/or Vice Chair) of the imminent suspension of privileges. If the medical record is not completed within 24 hours of receipt of notice from HIM, the MSA will notify the provider and suspend the provider's privileges.

b. Operative reports (which generally are required for any surgery involving making an incision and/or general anesthesia):

   i. **Time = 0**: The provider is identified by HIM as having an incomplete operative report if not dictated and/or completed in EPIC immediately after surgery. No specific notification of the provider is provided beyond flagging the electronic medical record (within EPIC in-basket).

   ii. **Time = 24 hours** after the provider is identified as non-compliant with medical records completion, HIM will evaluate the medical record to confirm responsibility, verify the operative report was truly not completed (as there may be a delay within transcription), and if appropriate, will establish person-to-person contact with the provider via email, pager, text messaging or phone call, as well as the provider's Department Secretary via phone call, to inform them of the delinquent medical record and imminent suspension of privileges. HIM will also notify Medical Staff Administration (MSA) that privileges should be suspended. The MSA will contact the provider's Department Secretary and Department Chair (and/or Vice Chair) of the imminent suspension of privileges. If the medical record is not completed within 24 hours of receipt of notice from

HIM, the MSA will notify the provider and suspend the provider's privileges.

4.9 Once the suspension of privileges for delinquent medical records has been initiated, the MSA will:

a. Contact the provider via phone call

b. Forward a suspension letter to the provider via email

c. Send a certified copy of the suspension letter to the provider via USPS.

d. Notify the provider's Department Chair (and/or Vice Chair).

e. Notify the Chief Medical Officer,

f. Notify the President of the Medical Staff,

g. Notify the Credentials Committee Chair,

h. Notify the Chief Nursing Officer,

i. Notify the Bed Management/ Registration, and

j. If applicable, notify the Perioperative Associate Chief Nursing Officer.

k. If applicable, unless directed otherwise by the medical staff president all elective surgeries scheduled by the provider for the day after the suspension begins will be cancelled.

4.10 While under suspension of privileges for delinquent medical records, no new non-emergent procedures or admissions will be allowed; however, the Medical Staff member will continue to treat patients already in the hospital until they are discharged.

4.11 The medical staff president may on a case by case basis decide to withhold suspension for delinquent records in emergent situations as necessary.

4.12 The practitioner will remain on suspension until the practitioner has completed all his/her delinquent medical records.

4.13 Once all delinquent records are completed, a monetary fine will be applied prior to reinstatement of privileges. Fine amounts payable to the Medical Staff Administration, on a rolling calendar year:

a. 1st suspension: $50

b. 2nd suspension: $100

c. 3rd suspension: $200

d. Fine continues to double

4.14 Upon completion of all delinquent records and fine has been paid, the MSA will notify the provider and personnel listed in section H, via email, pager, text messaging, or phone call, of reinstatement.

4.15 Exceptions may be made by the Medical Executive Committee for practitioners with delinquent medical records who are ill, on vacation, sabbatical, or another excused absence. In the practitioners absence, the delinquent medical records shall be re-assigned to the Department Chair (or Vice Chair) or another provider within the practitioners Department.

a. An exception may be made if it is determined by the Medical Director or Medical Staff President that suspension and/or removal from service may affect patient safety.

5. MONITORING

5.1 The Health Information Management Department shall conduct a monthly review encompassing all clinical services to ascertain chart completion compliance. Results shall be reported to the Physician Advisory Group, Professional Practice Evaluation Committee, and Medical Executive Committees for action.

6. SUSPENSION SANCTIONS

6.1 Enforcement of sanctions will be under the direction of the Department Chair (and/or Vice Chair), President of the Medical Staff, and Medical Executive Committee (MEC).

7. REFERENCES:

7.1 Title 22 Section 70751(g)

7.2 The Bylaws, Rules and Regulations of the Medical Staff or RUHS – Medical Center

7.3 The Joint Commission Standard RC. 01.01.01

7.4 42 CFR Part 482.24(b)(c)

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3/7/2017	Policy Approval Committee	Yes	
5/22/2017	Hospital Executive Committee	No	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 200	Page 1 of 10
Title: Financial Assistance For Low Income, Uninsured/Underinsured Patients	**Effective Date:** 11/13/2017	☐ **RUHS – Behavioral Health** ☐ **RUHS – Care Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. PURPOSE

1.1 The RUHS – Medical Center mission is to improve the health and well-being of our patients and communities through dedication to exceptional and compassionate care, education, and research. Our vision is to lead the transformation of healthcare and inspire wellness, in collaboration with our communities, through an integrated delivery network to bring hope and healing to those we serve. This policy demonstrates the RUHS – Medical Center commitment to our mission and vision by helping to meet the needs of the low income, uninsured patients and the underinsured patients in our community. This policy is not intended to waive or alter any contractual provisions or rates negotiated by and between RUHS – Medical Center and a third party payer, nor is it intended to provide discounts to a non-contracted third party payer or any other entity that is legally responsible for making payment on behalf of a beneficiary, covered person or insured.

1.2 This policy is intended to comply with California Health & Safety Code § 127400 et seq. (AB 774), Hospital Fair Pricing Policies, effective January 1, 2007, updated January 1, 2011, and January 1, 2015 (SB 1276), and United States Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") guidance regarding financial assistance to uninsured and underinsured patients. Additionally, this policy provides guidelines for identifying and handling patients who may qualify for financial assistance. This policy also establishes the financial screening criteria to determine which patients qualify for Financial Assistance program. The financial screening criteria in this policy are based primarily on the Federal Poverty Level ("FPL") guidelines updated periodically by HHS in the Federal Register.

2. SCOPE

2.1 This policy covers hospital inpatient and outpatient departments. An emergency physician, as defined in Section 127450, who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or High Medical Cost patients who are at or below 350 percent of the FPL. Emergency Room physician fees are covered under a separate policy. All other physician fees are excluded.

3. DEFINITIONS

3.1 Bad debt: A bad debt results from services rendered to a patient who is determined by RUHS – Medical Center, following a reasonable collection effort, to be able but unwilling to pay all or part of the bill.

3.2 Financial assistance patient: A financial assistance patient is a financially eligible Self-Pay patient or a High Medical Cost patient.

3.3 Emergent medical condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part; or

b. With respect to a pregnant woman who is having contractions:

- When there is inadequate time to effect a safe transfer to another hospital before delivery; or
- The transfer may pose a threat to the health or safety of the woman or the unborn child.

3.4 High medical cost patient: A financially eligible High Medical Cost patient is defined as follows:

a. Not self-pay (has third party coverage)

b. Patient's family income at or below 350% of the Federal Poverty Level (FPL)

c. Out-of-pocket medical expenses in prior twelve (12) months (whether incurred in or out of any hospital) exceeds 10% of Patient's Family income

3.5 Medically necessary service: A medically necessary service or treatment is one that is absolutely necessary to treat or diagnose a patient and could materially adversely affect the patient's condition, illness or injury if it were omitted, and is not considered an elective or cosmetic surgery or treatment.

3.6 Patient's family: For patients 18 years of age and older, patient's family is defined as their spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not. For persons under 18 years of age, patient's family means a parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

3.7 Reasonable payment plan: Monthly payments that are not more than 10 percent of a Patient's Family income for a month, excluding deductions for essential living expenses. "Essential living expenses" means, for purposes of this subdivision, expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto

expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

3.8 Self-pay patient: A financially eligible self-pay patient is defined as follows:

a. No third party coverage;

b. No Medi-Cal/Medicaid coverage or patients who qualify but who do not receive coverage for all services or for the entire stay;

c. No compensable injury for purposes of government programs, workers' compensation, automobile insurance, other insurance, or third party liability as determined and documented by the hospital;

d. Patient's Family income is at or below 350% of the Federal Poverty Level (FPL)

4. POLICY

4.1 This policy is designed to provide assistance to financially qualified patients who require medically necessary services, are uninsured, ineligible for third party assistance, or have high medical costs. Patients are granted assistance from unfunded financial assistance, State-funded California Healthcare for Indigent Program (CHIP), county programs, or grant programs for some or all of their financial responsibility depending upon their specific circumstances.

4.2 Patients with demonstrated financial need may be eligible if they satisfy the definition of a financial assistance patient or high medical cost patient as defined in section 3.8 of this document.

4.3 This policy permits non-routine waivers of patients' out-of-pocket medical costs based on an individual determination of financial need in accordance with the criteria set forth below. This policy and the financial screening criteria must be consistently applied to all cases throughout RUHS – Medical Center. If application of this policy conflicts with payer contracting or coverage requirements consult with RUHS – Medical Center legal counsel.

4.4 Services that are not medically necessary services or services that are separately-billed physician services are not eligible for Financial Assistance program. Emergency department physician services are covered under a separate policy.

4.5 This policy will not apply if the patient/responsible party provides false information regarding financial eligibility or if the patient/responsible party fails to make every reasonable effort to apply for and receive government-sponsored insurance benefits for which they may be eligible.

4.6 RUHS – Medical Center, will ensure that patients are made aware of the importance of financial screening and completion of necessary paperwork to gain appropriate healthcare coverage for costs incurred for healthcare services provided at RUHS - MEDICAL CENTER.

4.7 All patients will be provided emergency services in accordance with Emergency Medical Treatment & Active Labor Act (EMTALA) regulations. RUHS - MEDICAL CENTER staff will comply with federal and state laws regarding the conduct of county hospital financial business practices.

4.8 The Financial Assistance Program available through RUHS - MEDICAL CENTER will not substitute for personal responsibility of the patient. All patients are expected to contribute to the cost of their care based on their individual ability to pay.

4.9 Emergency Physicians, as defined in AB 1503, Stats. 2010, Ch. 445.) Section 127450, who provides emergency medical services in a hospital that provides emergency care, are also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350% of the Federal Poverty Level. This statement shall not be construed to impose any responsibilities upon the hospital.

4.10 Eligibility for the Financial Assistance Program will be consider for those individuals who are uninsured, underinsured, ineligible for any government health care benefits program and unable to pay for their care based upon a determination of financial need. Patients who are denied eligibility to government programs for failing to cooperate with the eligibility process will not be eligible for Financial Assistance.

4.11 Departmental Responsibilities

a. The RUHS - MEDICAL CENTER Financial Assistance shall be reviewed and updated to reflect the current Federal Poverty Level Guidelines (Attachment III).
b. MISP and Patient Accounts managers and staff will ensure that the policies and procedures established for the Financial Assistance Program are applied consistently. Likewise, registration shall provide to all patients the same information concerning services and charges for RUHS – Medical Center.
c. MISP eligibility staff will determine if the patient is required to apply for Federal or State sponsored programs. Patients not linked to SSI/SSDI, Medi- Cal, Medicare, or MISP will be screened for the RUHS – Medical Center Financial Assistance Program.
d. MISP eligibility staff will apply the following when determining eligibility for Financial Assistance:
    - Patient must meet the Resource limits established for the State of California's Medi-Cal program.
    - Monetary assets will be considered
    - The first $10,000 of monetary asset is exempt, 50% of all assets in excess of $10,000 are also exempt.
    - All remaining assets will be compared to the Medi-Cal resource limit. Individuals who exceed this limit will not qualify for assistance.
    - Retirement accounts, deferred compensation plans qualified under Internal Revenue code, or nonqualified deferred compensation plans are not included in the determination of monetary assets.
e. RUHS - MEDICAL CENTER will post and make available
    - A statement (Attachment I) that indicates that, if the patient meets certain income requirements, the patient may be eligible for a government-sponsored program or for the RUHS - MEDICAL CENTER Financial Assistance Program.
    - Notice (Attachment II) that provides information about the patient may be eligible for a government-sponsored program or for the RUHS - MEDICAL CENTER Financial Assistance Program. This notice will be posted in areas throughout the hospital.

4.12 Customer Service

a. Patients (or their legal representatives) seeking financial assistance will be asked to provide information quarterly concerning their health benefits coverage, financial status, and any other information that is necessary for RUHS – Medical

Center to make a determination regarding the patient's need for financial assistance.

b. Financial screening provided by MISP Eligibility staff, using eligibility criteria (income, family size), will determine the amount a patient is responsible to pay.
c. All RUHS – Medical Center staff shall be informed of availability of Financial Assistance Programs.

4.13 Eligibility

a. Patients with income at or below 100% of the federal poverty level are eligible for RUHS - MEDICAL CENTER Free Care Financial Assistance Program. Patients with combined income and assets at or below 350% of federal poverty level and are uninsured or underinsured will be eligible to apply for the RUHS - MEDICAL CENTER Partial Financial Assistance Program after all other types of assistance have been exhausted.
b. Patient with high medical costs" means an insured patient with high medical costs (co-payment, deductible, coinsurance and/or reached a lifetime limit, non-covered relating to services not medically necessary), with income at or below 350% of the Federal poverty level and not already receiving a discounted rate as a result of insurance coverage, then the patient may qualify for a discount from usual charges in accordance to the following guidelines herein, including but not limited to the California Fair Pricing Law. High medical costs" means (1) annual out-of-pocket costs incurred by the individual at the hospital that exceed 10 percent of the patient's family income in the prior 12 months, or (2) annual out-of-pocket expenses that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.
c. Patients who have demonstrated non-compliance with the conditions of SSI/SSDI, Medi-Cal, Medicare, MISP or any other referred assistance policy are not eligible for the RUHS - MEDICAL CENTER Financial Assistance Program.
d. Medi-Cal or Medicare beneficiaries with share of cost, deductible, and/or co-insurance do not constitute being underinsured.
e. Patients applying for the RUHS - MEDICAL CENTER Financial Assistance Program, who are denied eligibility have the right to file an appeal within 10 days. A patient has 10 days from the date that the county mailed or provided written Notice of Action (NOA). An appeal may be made by the patient contacting the RUHS - MEDICAL CENTER - MISP office to make an appointment with the appeals supervisor.
f. If determined to be eligible for the RUHS - MEDICAL CENTER Partial Financial Assistance Program by MISP eligibility staff, the patient will be referred to Patient Accounts to arrange payment of the hospital bill(s).
g. Documentation of the financial screening process will be retained by MISP according to MISP policy

4.14 Documentation Includes:

a. Date of determination of eligibility or denial for this program
b. Level of eligibility per the RUHS - MEDICAL CENTER Financial Assistance program
c. Copy of the application form
d. Copy of the approval or denial letter

4.15 Coverage Restrictions

a. Outpatient prescriptions and cosmetic surgeries are not covered under the RUHS - MEDICAL CENTER Financial Assistance Program.

4.16 Billing

a. Amounts payable to medical service providers other than RUHS - MEDICAL CENTER are excluded from this policy.
b. A Patient qualifying for assistance under the RUHS - MEDICAL CENTER Financial Assistance Policy and cooperating with Patient Accounts will not be referred to a collection agency.
c. A patient that fails to comply with requested financial updates will be responsible for payment of the original balance owned for their Hospital bill(s) in full.
d. In the event that the cost of medical care received at RUHS - MEDICAL CENTER is less than the amount the patient is responsible for, the patient will only be billed for the cost of those services. The cost of services provided will be determined using the most recently filed Medicare cost report.
e. Payment arrangements will be made for any amount owed that exceeds 10% of the monthly income of the patient. Payment plans will not exceed 12 months.
f. If a patient is cooperating and complying with the payments required according to the established responsibility for that patient, RUHS – Medical Center will not place wage garnishments or liens on primary residencies or other properties as a means of collecting the unpaid hospital UMDAP (Uniform Method of Determining Ability to Pay) bills.
g. If a patient fails to comply with their established payment plan for more than 90 days, the payment plan may be declared inoperable and the patient will be responsible for payment of the original balance owed for their Hospital bill(s) in full. Patient Accounts will attempt to contact the patient at the last known address and at the last known phone number of the patient to re-negotiate the payment plan prior to declaring any payment plan inoperable.
h. If it is determined an overpayment by the patient has occurred, RUHS – Medical Center will refund any amount owed within 30 days of the determination. Interest owed on this overpayment by the hospital to the patient will be paid to the patient at the statutory rate (10% per annum) according to Civil Procedure Code 685.010 and Health and Safety Code section 127440. Interest will be accrued beginning on the date payment was received by the hospital. If the amount of interest due to the patient is less than five dollars ($5.00), the hospital is not required to pay the interest.
i. RUHS – Medical Center contracted collection agencies; billing services are required to conform to the billing/collection practices outlined in this policy.

5. REFERENCES

5.1 2004 CHA Voluntary Principles and Guidelines for Assisting Low Income, Uninsured Patients.

5.2 MISP policy number MISP 10

5.3 MISP policy number MISP 14

5.4 MISP policy number MISP 20

5.5 MISP policy number MISP 21

6. ATTACHMENTS

6.1 RUHS – Medical Center Financial Assistance Statement

6.2 RUHS – Medical Center Financial Assistance Notice

6.3 Federal Poverty Guidelines

ATTACHMENT 6.1

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER FINANCIAL ASSISTANCE PROGRAM

To meet the needs of the uninsured/underinsured patients who have received healthcare services at RUHS – MEDICAL CENTER and are unable to pay for these services, programs have been established to assist RUHS - MEDICAL CENTER patients to gain access to programs that may assist the patient with payment of their Hospital bill along with additional medical services that may be required.

These programs include, but are not limited to:

Medi-Cal
Medicare
MISP
RUHS - MEDICAL CENTER Financial Assistance – UMDAP

Inpatient Services – Patients expressing concern with payment for Hospital services should be referred to the Inpatient MISP Eligibility staff for assistance.

Outpatient/Emergency Room Services – Patients expressing concern with payment for outpatient or emergency room services can be referred to the MISP office to pick up an MISP/RUHS - MEDICAL CENTER Financial Assistance Program application and schedule an appointment to meet with an MISP eligibility staff.

As part of the interview/screening appointment with the MISP eligibility staff, the patient requesting assistance will be screened for eligibility for all programs named above.

Medically Indigent Services Program (MISP)
RUHS - MEDICAL CENTER Financial Assistance Program
14375 Nason Street Suite 102
Moreno Valley Ca 92555
951-486-5375
Espanol 951-486-5400

Medi-Cal	MISP	Medicare
951-486-5750	1-877-501-5085	1-800-633-4227

ATTACHMENT 6.2

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
FINANCIAL ASSISTANCE PROGRAM

To meet the needs of the uninsured/underinsured patients who have received healthcare services at RUHS - MEDICAL CENTER and are unable to pay for these services, programs have been established to assist RUHS - MEDICAL CENTER patients to gain access to programs that may assist the patient with payment of their Hospital bill along with additional medical services that may be required.

These programs include, but are not limited to:

Medically Indigent Services Program (MISP)
RUHS - MEDICAL CENTER Financial Assistance Program
14375 Nason Street Suite 102
Moreno Valley Ca 92555
951-486-5375
Español 951-486-5400

Medi-Cal	MISP	Medicare
951-486-5750	1-877-501-5085	1-800-633-4227

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

ATTACHMENT 6.3

Annual 2017 Poverty Guidelines for the 48 Contiguous States

Household/ Family Size	25%	50%	75%	100%	125%	150%	175%	185%	200%	225%	250%	275%	300%	325%	350%	375%	400%
1	3,015	6,030	9,045	12,060	15,075	18,090	21,105	22,311	24,120	27,135	30,150	33,165	36,180	39,195	42,210	45,225	48,240
2	4,060	8,120	12,180	16,240	20,300	24,360	28,420	30,044	32,480	36,540	40,600	44,660	48,720	52,780	56,840	60,900	64,960
3	5,105	10,210	15,315	20,420	25,525	30,630	35,735	37,777	40,840	45,945	51,050	56,155	61,260	66,365	71,470	76,575	81,680
4	6,150	12,300	18,450	24,600	30,750	36,900	43,050	45,510	49,200	55,350	61,500	67,650	73,800	79,950	86,100	92,250	98,400
5	7,195	14,390	21,585	28,780	35,975	43,170	50,365	53,243	57,560	64,755	71,950	79,145	86,340	93,535	100,730	107,925	115,120
6	8,240	16,480	24,720	32,960	41,200	49,440	57,680	60,976	65,920	74,160	82,400	90,640	98,880	107,120	115,360	123,600	131,840
7	9,285	18,570	27,855	37,140	46,425	55,710	64,995	68,709	74,280	83,565	92,850	102,135	111,420	120,705	129,990	139,275	148,560
8	10,330	20,660	30,990	41,320	51,650	61,980	72,310	76,442	82,640	92,970	103,300	113,630	123,960	134,290	144,620	154,950	165,280
9	11,375	22,750	34,125	45,500	56,875	68,250	79,625	84,175	91,000	102,375	113,750	125,125	136,500	147,875	159,250	170,625	182,000
10	12,420	24,840	37,260	49,680	62,100	74,520	86,940	91,908	99,360	111,780	124,200	136,620	149,040	161,460	173,880	186,300	198,720
11	13,465	26,930	40,395	53,860	67,325	80,790	94,255	99,641	107,720	121,185	134,650	148,115	161,580	175,045	188,510	201,975	215,440
12	14,510	29,020	43,530	58,040	72,550	87,060	101,570	107,374	116,080	130,590	145,100	159,610	174,120	188,630	203,140	217,650	232,160
13	15,555	31,110	46,665	62,220	77,775	93,330	108,885	115,107	124,440	139,995	155,550	171,105	186,660	202,215	217,770	233,325	248,880
14	16,600	33,200	49,800	66,400	83,000	99,600	116,200	122,840	132,800	149,400	166,000	182,600	199,200	215,800	232,400	249,000	265,600

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

Document History:

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Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
6/30/2016	MISP		
10/3/2017	Policy Approval Committee (PAC)	Y	Minor formatting and wording
11/13/2017	Hospital Executive Committee	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

	Document No: 600.3	Page 1 of 9
Title: Patient Medical Records	**Effective Date:** 7/5/2017	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Zareh Sarrafian, CEO/ Hospital Director		☐ Policy ☒ Procedure ☐ Guideline

1. PROCEDURES

1.1 Maintenance of Electronic Health Record (EHR); (Medical Record)

a. Medical records shall be physically maintained in a safe and secure area in the hospital or in an approved off-site storage facility. Safeguards to prevent loss, destruction, and tampering shall be implemented by all workforce members.

1.2 All patient records, either as original or accurate reproductions of the contents of such originals, shall be maintained in such form as to be legible and readily available upon the request of:

a. The admitting licensed healthcare practitioner acting within the scope of his or her professional licensure.

b. The non-physician granted privileges pursuant to CCR 70706.1.

c. The hospital, its medical staff, or any authorized officer, agent or employee of either.

d. Any other person authorized by law to make such a request.

1.3 The medical record is currently maintained as a hybrid record. Documentation that comprises the medical record may physically exist in separate and multiple locations in both paper and electronic form. Any previous legacy systems that were not interfaced are still owned by the managers of those areas (i.e. OBTraceVu) and are accessed directly with those system owners as needed.

1.4 Electronic records are available in real-time as they are processed and authenticated in the EHR system.

1.5 Original point of care hand written medical record documentation must be sent to the Health Information Management (HIM) department to be scanned into the patient's permanent EHR.

1.6 All documentation shall be assessed to ensure that the written/stamped patient identification that resides on each document is for the correct patient prior to being entered into the EHR.

1.7 Paper Records (prior to EPIC implementation) are maintained offsite in an approved record storage facility and can be obtained 24/7 via an authorized requester.

1.8 Availability of medical records depends on authorized access and request type.

1.9 Confidentiality

a. The Medical Record is confidential and is protected from unauthorized disclosure by law.

b. The circumstances under which RUHS – Medical Center may use and disclose confidential medical record information is set forth in the Notice of Privacy Practices and in other RUHS – Medical Center Privacy Policies and Procedures.

c. Under the HIPAA Privacy Rule, an individual has the right to access and/or amend his or her protected health information (PHI) that is contained within a designated record.

1.10 Components of the patient medical record.

a. Medical record content shall meet all federal and state legal, regulatory and accreditation requirements.

b. All hospital medical records and hospital-based clinic records must also comply with the RUHS – Medical Center Medical Staff Bylaws for content and timely completion.

c. All documentation and entries in the medical record, both paper and electronic, must be identified with the patient's full name, date of birth, and medical record number (MRN).

d. The medical record includes both written and electronic documentation and shall include the following items (if applicable). Information:

- Needed to support the patient's diagnosis and condition.
- That documents the course and result of the patient's care, treatment, and services.
- About the patient's care, treatment, and services that promote continuity of care among providers.
- That is patient identifiable source information, such as photographs, digital images, and films, monitoring strips and/or written or dictated summaries or interpretation of findings.
- Required in Attachment I. *Required Elements of the Patient Medical Record.*

1.11 Record Authentication

a. Only authorized individuals shall make entries in the medical record.

b. All entries in the medical record shall meet the standards for data integrity by meeting the following guidelines:

- Every medical record entry must be dated, its author identified and, when necessary, authenticated. Signatures must be legible or accompanied by the legibly printed name on hand written documentation.
- Countersignatures or dual signatures are used as required by state law and RUHS – Medical Center Medical Staff Bylaws.
- Initials may be used to authenticate entries on flow sheets or medication records, and the document must include a key to identify the individuals whose initials appear on the document.
- Only an author can authenticate his or her own entry. Indications of authentication can include written signatures or initials, dictation entries, rubber stamps, or computer "signatures" (or sequence of keys).
- No individual shall share electronic signature keys with any other individual.

1.12 Timeliness

a. Documentation in the medical record will be entered in a timely manner.

b. The healthcare provider will record the patient's medical history and physical examination, including updates, in the medical record within 24 hours after inpatient admission or registration, but prior to surgery or a procedure requiring anesthesia.

c. All inpatient medical records must be completed within 14 days from the date of a patient's discharge (California Code of Regulations, Title 22, section 70751).

d. A report of all operations performed or a procedure progress note shall be immediately written, dictated or completed electronically by the attending or resident physician within 24 hours. (See *RUHS – Medical Center Medical Staff Bylaws- Rules and Regulations No. 10*)

e. Verbal and/or telephone orders for administration of medication are restricted to emergency situations (see *RUHS – Medical Center policy HW 803 Verbal/Telephoned Orders for Drugs*) and must be reviewed and countersigned by the physician within 48 hours.

1.13 Correction to the Record

a. Patients may request a medical record amendment and/or a medical record addendum. Refer to RUHS – Medical Center policy HW 709 *Amendments and Addendums to the Medical Record* for handling patient requests for record amendment and record addendums.

b. When an error is made in a medical record entry, the original entry must not be obliterated, removed, or destroyed and the inaccurate information should still be accessible.

c. If information in a paper medical record must be corrected or revised:

- Draw a single line through the incorrect entry and write "error".
- Initial this error and write the date and time.
- Note revision.

d. If the document was originally created in a paper format, and then scanned electronically, the electronic version must be corrected by printing the documentation, correcting as above, and rescanning the document.

e. Mechanisms for making corrections to the direct entry of clinical documentation vary from one system to another but shall follow the same basic principles as corrections to the paper record. When adding addendums for correcting documents that are created electronically, include the following:

- The corrected information.
- The identity of the individual who created the addendum.
- The date created.
- The electronic signature of the individual making the addendum.

f. Consent forms should not be corrected unless the change is limited and the patient and provider each write their initials, the date, the time, and the change made. If an error is made on the consent form, a new form is required to be completed with the patient and witness of the patient's signature.

1.14 Late Entry. When a pertinent entry was missed or not written in a timely manner, the author must meet the following requirements:

a. Identify the new entry as a "late entry."

b. Enter the current date and time – do not attempt to give the appearance that the entry was made on a previous date or an earlier time.

c. Sign the entry.

d. Refer to the date and circumstance for which the late entry or addendum is written.

e. Document as soon as possible. The longer the time lapse, the less reliable the entry becomes.

1.15 Audit Requirements

a. The hospital will ensure that there is ongoing review of medical records at the point of care, based on the following indicators:

- Presence
- Timeliness
- Legibility (whether handwritten or printed)
- Accuracy
- Authentication
- Completeness of data and information

b. The hospital will also measure the hospital medical record delinquency rate at regular intervals but no less than every three months. The medical record delinquency rate is:

- Averaged from the last four quarterly measurements will be acceptable at 50% or less of the average monthly discharge (AMD) rate.
- Each individual quarterly measurement will be acceptable if it is no greater than 50% of the AMD rate.

1.16 Record Retention. Medical records will be retained in compliance with Federal and State laws and County of Riverside Retention Policy, *Records Retention Management*.

1.17 Urgent/Emergent-Care Services. The medical record of a patient who receives urgent or emergency care, treatment, and services will contain all of the following:

a. The time and means of arrival.

b. Indication that the patient left against medical advice or left before being seen, when applicable.

c. Conclusions reached at the termination of care, treatment, and services, including the patient's final disposition, condition, and instructions given for follow-up care, treatment, and services.

d. A copy of any information made available to the practitioner or medical organization that is expected to provide follow-up care, treatment, and services.

1.18 Operative and High-Risk Procedures

a. The patient's medical record will document operative or other high-risk procedures, and the use of moderate or deep sedation or anesthesia (see RUHS Policy No. 628, *Moderate (Conscious) and Deep Sedation/Analgesia.*)

b. A licensed independent practitioner involved in the patient's care will document the provisional diagnosis in the medical record before an operative or other high-risk procedure is performed.

c. The patient's medical history and physical examination will be recorded in the medical record before an operative or other high-risk procedure is performed

d. An operative or other high-risk procedure report will be written, completed electronically, or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care. Exceptions to this requirement:

- When an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within 24 hours.
- If the practitioner performing the operation or high-risk procedure accompanies the patient from the operating room (OR) to the next unit or area of care, the report can be written, completed electronically or dictated in the new unit or area of care.

e. The operative or other high-risk procedure report will include the following information:

- The name(s) of the licensed independent practitioner(s) who performed the procedure and his/her assistant(s).
- The name of the procedure performed.
- A description of the procedure.
- Findings of the procedure.
- Any estimated blood loss.
- Any specimen(s) removed.
- The postoperative diagnosis.

f. When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note will be entered in the medical record before the patient is transferred to the next level of care. This progress note will include:

- The name(s) of the primary surgeon(s) and assistant(s).
- The procedure performed.
- A description of each procedure finding, estimated blood loss, specimen(s) removed, and postoperative diagnosis.

g. The medical record will contain the following postoperative information:

- The patient's vital signs and level of consciousness.
- Any medications, including intravenous fluids and any administered blood, blood products, and blood components.
- Any unanticipated events or complications (including blood transfusion reactions) and the management of those events.

h. The medical record will contain documentation that the patient was discharged from the post-sedation or post-anesthesia care area either by the

licensed independent practitioner responsible for his/her care or according to discharge criteria.

i. The medical record will contain documentation of the use of approved discharge criteria that determine the patient's readiness for discharge.

j. The postoperative documentation will contain the name of the licensed independent practitioner responsible for discharge.

1.19 Restraint and/or Seclusion. Refer to RUHS – Medical Center policy HW 630 Restraints and Seclusion and to RUHS – Medical Center Psychiatric Unit Emergency Treatment Services (ETS) and Inpatient Treatment Services (ITF), Arlington Campus, policies for documentation requirements for restraint and/or seclusion.

1.20 Summary/Problem Lists.

a. The medical record will contain a summary list (problem list) for each patient who receives continuing ambulatory care services. The summary list will be initiated for the patient by his/her third visit and will contain the following information:

- Any medical diagnoses and significant conditions.
- Any operative and invasive procedures.
- Any adverse or allergic drug reactions.
- Any current medications, over-the-counter medications, and herbal/holistic preparations.

b. The patient's summary list will be updated whenever there is a change in diagnosis, medication, or allergy to medication(s) and whenever a procedure is performed.

1.21 Discharge Information

a. Patient discharge information will be documented in the medical record.

b. In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record will contain a concise discharge summary that includes the following:

- The reason for hospitalization.
- The procedures performed.
- The care, treatment, and services provided.
- The patient's condition and disposition at discharge.
- Information provided to the patient and family.
- Provisions for follow-up care.

c. A discharge summary is not required when a patient is seen for outpatient services or presents to the emergency department and is not admitted as inpatient. In this instance, a final progress note or summary of care may be substituted for the discharge summary.

1.22 Ownership, Security of Medical Records

a. All medical records of RUHS – Medical Center patients are owned by RUHS – Medical Center, regardless of whether they are created at, or received by RUHS – Medical Center.

b. Patient lists and billing information are property of RUHS – Medical Center and the County of Riverside.

c. The information contained within the medical record must be accessible to the patient and thus made available to the patient and/or his or her legal representative upon appropriate request and authorization by the patient or his or her legal representative.

d. Original records may not be removed from RUHS – Medical Center facilities except by court order, subpoena, or as otherwise required by law.

e. If an employed physician or provider separates from or is terminated by RUHS – Medical Center for any reason, he or she may not remove any original or shadow copies of medical records, patient lists, and/or billing information from RUHS – Medical Center facilities and/or offices.

f. For continuity of care purposes, and in accordance with applicable laws and regulations, patients may request a copy of their records be forwarded to another provider upon written request to RUHS – Medical Center.

2. REFERENCES

2.1 Medicare Conditions of Participation 42 CFR Section 482.24.

2.2 County of Riverside Records Retention Policy.

2.3 RUHS – Medical Center policy HW 700 Patient Privacy – HIPAA.

2.4 RUHS – Medical Center policy HW 628 Moderate Conscious and Deep Sedation/Analgesia.

2.5 RUHS – Medical Center policy HW 630 Restraint and Seclusion

2.6 RUHS – Medical Center policy HW 709 Amendments and Addendums to the Medical Record.

2.7 The Joint Commission Standards, Record of Care, Treatment and Services.

2.8 Title 22 California Code of Regulations, sections 70749, 70527, 70751 and 71549.

3. ATTACHMENTS

3.1 Required Elements of the Patient Medical Record (The Joint Commission Standard Record of Care, Treatment, and Services)

ATTACHMENT I. REQUIRED ELEMENTS OF THE PATIENT MEDICAL RECORD

(The Joint Commission Standard Record of Care, Treatment, and Services)

1. The patient medical record will contain the following demographic information:
   - Patient's name, address, date of birth, and the name of any legally authorized representative
   - Patient's sex (gender)
   - Identification number (if applicable)
     - Social Security
     - Medicare
     - Medi-Cal
   - Legal status of any patient receiving behavioral health-care services
   - Patient's language and communication needs

2. The patient medical record will contain the following clinical information:
   - Date of Admission
   - Date of Discharge
   - Name of patient's admitting licensed health care practitioner acting within the scope of his or her professional licensure.
   - The reasons for admission for care, treatment, and service.
   - The patient's initial diagnosis, diagnostic impression(s), or condition(s)
   - Any findings of assessments and reassessments
   - Any allergies to food
   - Any allergies to medications
   - Any conclusions or impressions drawn from the patient's medical history and physical examination
   - Any diagnoses or conditions established during the patient's course of care, treatment, and services
   - Any consultation reports
   - Any observations relevant to care, treatment, and services
   - The patient's response to care, treatment, and services
   - Any emergency care, treatment, and services provided to the patient before his/her arrival at the hospital
   - Any progress notes
   - All orders
   - Any medications ordered or prescribed
   - Any medications administered, including the strength, dose, and route
   - Any access site for medication, administration devices used, and rate of administration
   - Any adverse drug reactions
   - Treatment goals, plan of care, and revisions to the plan of care
   - Results of diagnostic and therapeutic tests and procedures
   - Any medications dispensed or prescribed on discharge
   - Health care associated infections
   - Complications
   - Discharge or final diagnosis
   - Nursing notes
   - Vital signs
   - Discharge plan and evaluation results

3. As needed to provide care, treatment, and services, the patient medical record will contain the following additional information:
   - Any Advance Directive
   - Any informed consent (as required by RUHS Policy No. 602, *Patient Informed Consent*)
   - The Health Insurance Portability and Accountability Act (HIPAA) required acknowledgement form for the *Notice of Privacy Practices* (not required for patients in legal custody; i.e., jail inmates, prisoners)
   - Any record of communication with the patient, such as telephone calls or e-mail
   - Any patient-generated information

Document History:

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5/2017	Director, Health Information Management	Y	Minor wording changes throughout document
6/2017	Policy Approval Committee	Y	Minor wording changes
7/5/2017	Hospital Executive Committee	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

Title:	Document No: 601.1	Page 1 of 3
Mental Health Patient Rights	Effective Date: 7/5/2017	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Zareh Sarrafian, CEO/ Hospital Director		☒ Policy ☐ Procedure ☐ Guideline

1. DEFINITIONS

1.1 Conservatorship. Court appointed to arrange for care and protection, decides where conservatee will live, and is generally in charge of health care, food, clothes, personal care, housekeeping, and transportation of another person.

2. POLICY

2.1 Mental Health patients have the right to:

a. Wear their own clothes.
b. Keep and use their own personal possessions, including toilet articles.
c. Keep and be allowed to spend a reasonable sum of their own money for minor expenses and small purchases.
d. Have access to individual storage for their own private use.
e. See visitors each day.
f. Have reasonable access to telephones, both to make and receive confidential calls or to have such calls made for them.
g. Have reasonable access to letter writing materials, including stamps, and to mail and receive unopened correspondence.
h. Refuse convulsive treatment. (NOTE: RUHS – Medical Center does not provide electroconvulsive treatment (ECT) on site at any of its facilities but may make a referral for the patient to another hospital for this purpose).
i. Refuse psychosurgery.
j. See and receive the services of a patient advocate who has no direct or indirect clinical or administrative responsibility for the person receiving mental health services.
k. Other rights, as specified by regulations.

2.2 Notification of Rights

a. Upon admission, each mental health patient will be notified personally of their rights in writing, in a language understandable by the patient or will have the rights conveyed by other means as necessary. Giving each mental health patient a copy of the Patient Rights Handbook fulfills this requirement in most cases. A notation to the effect that notification, or an attempt to provide notification, has occurred, will be entered into the patient's medical record within 24 hours of admission by the nurse.
b. Incomplete advisement may occur by necessity under certain circumstances. The nurse will document the good cause for incomplete advisement, ensuring that subsequent attempts to advise are made and documented as well.

2.3 Posted Rights Listing. A listing of mental health patient rights shall be posted in English and Spanish at each nursing station where mental health patients have beds in the unit. The listing include:

a. Name, telephone number, availability of the RUHS – Medical Center Hospital Patient advocate.

b. Riverside County
Department of Mental Health Patient Rights' Advocate to whom a complaint may be directed.
c. Name and phone number of the State Patient's Rights Office.

2.4 Denial of Rights. The Chief of Psychiatry or designee may for good cause deny a person any of the rights listed under W&IC Section 5325 except for letter writing materials as listed in 2.1 g. above. The right to have reasonable access to telephones as listed in 2.1 f. above, may be denied only under the conditions specified in Section 5325.7 of the W&IC.

a. The good cause for denial will meet the definition stated in Title 9, Article 6, Section 865.2. Good cause exists when there is good reason to believe that:
- The exercise of a specific right would be injurious to the patient.
- The exercise of a specific right would seriously infringe on the rights of others.
- The hospital would suffer serious damage in the specific right is not denied.
- There is no less restrictive way of protecting the interests specified in 2.1 f. and g. above.

b. The reason used to justify the denial of a right must be related to the specific right denied.
c. A right will not be withheld or denied as a punitive measure nor will a right be considered a privilege to be earned.
d. Treatment modalities will not include denial of any right.
e. Waivers signed by a patient or responsible relative/guardian/conservator will not be used as a basis for denial of a right.
f. Parents, conservators, or other legally responsible persons (other than the licensed psychiatrist) shall not be allowed to deny patient rights of a minor.
g. Each denial of a patient's right will be noted in the medical record, and the patient will be informed of a content of the notation. Documentation will occur immediately upon denial of the right and will include:
- The date and time of the right was denied.
- The specific right denied.
- Good cause for denial of the right.
- Date of review if denial is extended beyond 30 days.
- Signature of the Chief of Psychiatry or designee.
- Use of restraints or seclusion constitutes denial of rights and must be documented in the case record.

2.5 Restoration of Rights.

a. A right may not be denied to a patient when good cause for that right no longer exists.
b. Staff must employ the least restrictive method of managing the problem that led to the denial.
c. The date a specific right is restored must be documented in the patient record.

2.6 Rights Which Cannot be Denied. Section 5325.1 of the W&IC adds the following rights, which may not be denied:

a. A right to treatment services which promote the potential of the person to function independently. Treatment shall be provided in ways that are least restrictive of personal liberty of the individual.
b. A right of dignity, privacy and humane care.
c. A right to be free from harm, including unnecessary or excessive physical restraint, isolation, medication, abuse or neglect. Medication shall not be

used as punishment, for the convenience of staff, as a substitute for a treatment program, or in quantities that interfere with the treatment program.

d. A right to prompt medical care and treatment.
e. A right to religious freedom and practice.
f. A right to participate in appropriate programs of publicly supported education.
g. A right to social interaction and participation in community activities.
h. A right to physical exercise and recreational opportunities.
i. A right to be free from hazardous procedures.

2.7 Quarterly Report. Nursing Administration will prepare a monthly and a quarterly report of the number of mental health persons whose rights were denied and the specific right or rights denied for submission to the Department of Mental Health.

3. REFERENCES

3.1 RUHS – Medical Center policy HW 630 Restraints and Seclusion
3.2 W&IC Section 5325
3.3 Title 9, CCR Section 862
3.4 Title 22 CCR Section 71507; Welfare and Institutions Code 5326
3.5 Title 9 CCR, Section 865.3 and 865.4

Document History:

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7/5/2017	Hospital Executive Committee	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 601.6	Page 1 of 3
Title: Disclosing Unexpected Outcomes or Medical Errors to Patients	**Effective Date:** 9/2/2017	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank, CEO/ Hospital Director		☐ Policy ☒ Procedure ☐ Guideline

1. DEFINITIONS

1.1 Unanticipated Outcome is an outcome that is out of the ordinary or unexpected and not consistent with the routine care and treatment related to the patient's admitting or working diagnosis. An unanticipated outcome may be positive, negative, or neutral.

1.2 Medical Error is the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures and systems.

2. PROCEDURES

2.1 Unanticipated outcomes and medical errors will be disclosed to patients.

2.2 The following examples demonstrate disclosure opportunities, all meriting disclosure to patients:

a. The error or outcome occurred but the patient was not harmed.

b. The error or outcome created a need for increased patient assessments, but no change in vital signs and no patient harm.

c. The error or outcome resulted in temporary patient harm, as well as a need for treatment or intervention or prolonged hospitalization.

d. The error or outcome resulted in permanent patient harm or near death.

e. The error or outcome was unanticipated and resulted in death.

2.3 The responsibility of disclosing errors and unanticipated outcomes to the patient and family is the responsibility of the physician or designee most closely associated with the error or outcome.

2.4 Unless otherwise directed, clinical staff members shall direct questions from the patient or his or her designated decision maker about an unanticipated outcome or error to the physician most closely associated with the outcome or error

2.5 The error or unanticipated outcome shall be disclosed to the patient if he or she has decision-making capacity, unless the patient expresses a preference that the disclosure be made to his or her designated decision maker. If the patient lacks

capacity, the disclosure shall be made to the patient's designated decision maker.

2.6 The initial disclosure shall be made as soon as practical in the best interest of the patient, as determined by the disclosing physician. Usually this will take place within 24-48 hours of the error or unanticipated outcome.

2.7 Physicians identifying the need for a disclosure should, if possible, notify the Chair of their Department or, if that individual is not readily available, the Chief Medical Officer of the disclosure. Physicians should also be aware of the potential impacts on other staff and consider notifying the supervisors of those most involved to provide a resource(s) for them.

2.8 Disclosures should take place in a private area where the patient, physician and others that the patient desires to be present may speak freely without being concerned about being overheard.

2.9 The disclosure shall include:

a. A truthful, and factual account of the unanticipated outcome or error.

b. Any short or long-term effects expected as a result of the unanticipated outcome or error

c. Any medical care or treatment available to the patient required as a result of the error or unanticipated outcome, including the risks, benefits and alternatives of such care and treatment.

d. Assurance that any unanticipated outcome or error will be evaluated so that steps may be taken to reduce the likelihood of a similar risk to any other patient.

e. Time for the patient and/or family or representative to ask questions or raise concerns and share their feelings..

f. The name and contact information of the individual(s) responsible for managing ongoing communications with the patient and the patient's family members regarding additional questions, complaints and follow-up.

2.10 The disclosure shall NOT include:

a. Blame or criticism assigned to any physician, staff member, policies, or practices of RUHS-Medical Center.

b. Speculation as to how events occurred if the mechanism or error is unknown

c. Statements of assessing fault or liability for causing the unanticipated outcome or error.

d. A discussion of financial issues with the patient. If the patient or a patient family member raises such issues the disclosing physician should defer discussion on those issues and notify hospital administration.

2.11 Disclosures may require more than one communication, particularly if there is a need to await test results or other significant additional information. The patient should be kept apprised of any delays.

2.12 The physician who makes the disclosure shall note the circumstances of the disclosure in the progress notes section of the patient's medical records.

a. The note shall include:

- A factual summary of what was disclosed
- The individuals present during the disclosure
- The time, date, and place of the discussion

b. The note shall not include

- Suspicions, opinions and non-clinical information regarding the unanticipated outcome or error. Any follow-up discussions shall be noted in the same manner.
- Mention of any reports that may be submitted to administration, quality, risk management or governmental/accrediting agencies.

2.13 For guidance on reporting requirements of unexpected outcomes please refer to:

a. RUHS-Medical Center policy HW 122 Incident Reporting

b. RUHS – Medical Center policy HW 610 Reporting Never Events

c. RUHS-Medical Center policy HW 654 Sentinel Events

3. REFERENCES

3.1 The Joint Commission RI.01.02.01 EP 21

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8/10/2017	Medical Executive Committee	No	
9/5/2017	Hospital Executive Committee	No	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 602	Page 1 of 4
Title: Patient Informed Consent	**Effective Date:** 10/3/2017	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☒ Policy ☐ Procedure ☐ Guideline

1. DEFINITIONS

1.1 **Informed Consent** – A process of obtaining and documenting permission before conducting a healthcare intervention on a person. It involves discussion between a physician and the patient or patient's legal representative about the nature of the procedure, the potential risks, benefits and alternatives to the treatment.

1.2 **Medical Emergency**. A medical emergency exists when:

a. Immediate services are required for the alleviation of severe pain

OR

b. The procedure is required for immediate diagnosis and treatment of unforeseeable medical conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death.

AND EITHER

a. The patient is unconscious or incapable of giving consent and there is insufficient time to obtain informed consent from the patient's legal representative

OR

b. The procedure has to be undertaken immediately and there is insufficient time to fully inform the patient or a legal representative of possible consequences.

2. POLICY

2.1 RUHS – Medical Center honors each patient's right to give or withhold consent for medical treatment.

2.2 No treatments, other than treatments needed to address a medical emergency, will be permitted unless the patient, or a person legally authorized to consent on the patient's behalf, has consented to treatment.

2.3 **Emergencies** - In the case of a medical emergency:

a. Only the emergency condition may be treated.

b. The medical determination that an emergency exists must be documented by the physician and placed in the medical record.

c. Treatment that exceeds what is necessary for the emergency condition may not be rendered without consent from someone authorized to consent to treatment on a nonemergency basis.

d. The medical emergency treatment exception is not applicable when a patient has validly refused medical treatment, and the emergency arises from the fact that treatment was not given.

e. If evidence exists to indicate that the patient (or the patient's legal representative) would refuse the treatment, legal counsel shall be consulted.

f. The following types of procedures will require documentation of informed consent before they are performed on a non-emergency basis:

g. Operative procedures

h. Invasive procedures that have the potential for serious risks and / or adverse reactions

i. Blood transfusions or other use of blood products

j. Planned use of all forms of anesthesia and moderate sedation

k. Electroconvulsive therapy

2.4 It is the treating physician's responsibility to obtain informed consent prior to beginning medical treatment.

a. The physician who performs the treatment is responsible for obtaining the patient's consent.

b. If a non-physician will perform the procedure, then the ordering physician is responsible for securing the consent.

c. If more than one physician is providing the treatment, they can determine together which physician will obtain consent.

2.5 The physician will provide the information to the patient or legal representative, answer any questions about the procedure, sign and then have the patient sign and date the informed consent form. A copy of the signed informed consent form may be provided to the patient and the original copy will be placed in the patient's chart/medical record.

2.6 Informed Consent must include:

a. Assessment of the patient's capacity to understand the discussion or location of an appropriate substitute decision maker if the patient is incapable by age, mental state or medical condition of understanding the decision under discussion.

b. A discussion about the patient's proposed care, treatment, and services.

c. Potential risks, benefits, and alternatives to the proposed care, treatment, and services.

d. Any potentially conflicting interests the physician may have such as research or financial interests.

2.7 **Consent by telephone** - Consent for medical or surgical procedures should be obtained by telephone only if the person having the legal ability to consent for the patient is not otherwise available. The telephone discussion between the physician and the patient's legal representative and a responsible hospital employee should be confirmed by either (a) the physician and one hospital employee or (b) by two hospital employees and documented in the telephone consent section of the informed consent with name, signature, title, date and time.

2.8 **Interpreters** - If a patient or his/her legal representative cannot communicate with the physician due to a language or communication barrier, the physician will arrange for an interpreter according to the instruction in RUHS – Medical Center policy *HW 142 Access to Language Services for Non or Limited English Proficient, Deaf, and Hearing Impaired Persons.* If an interpreter is used in person, the interpreter will sign, date, and time on the informed consent form. If an interpreter is used on line or on phone, the required information will be documented along with the Interpreter's telephone ID on the informed consent form.

2.9 **Nursing role** - The nurse will ensure that the appropriate informed consent form has been signed and is in the medical record prior to the procedure being done.

2.10 **Abbreviations** - Abbreviations should not be used in the informed consent form.

2.11 **Corrections** - When discussing the informed consent form with the patient prior to the procedure and an error is made on the form, either prepare a new form or use a single line through the material to be deleted. The physician and patient must initial, date, and time each correction made to the form.

2.12 **Names of practitioners** - The names of the practitioner(s) performing the procedure(s) must be included in the form. Use of medical group practice name or use of a surgeon's name followed by "and associates" is not acceptable. Also, the name(s) of other practitioners who will conduct specific, significant surgical tasks not being done by the primary surgeon/practitioner, should be included on the informed consent.

2.13 **Refusal to Consent** – Patient and those giving consent on their behalf are entitled to refuse any and all recommended care and treatments. The physician's duty is to make every effort to explain the risks, benefits and likely consequences of refusing the recommended treatment so that such refusals are informed by that information.

a. Refusals of recommended care or treatments should be documented in the patient's chart;

b. Consultation by psychiatry or with the RUHS Bioethics Committee may be indicated if there are questions about the patient's capacity to appreciate the consequences of such a refusal, whether refusal by a substitute decision-maker is in the patient's best interest or the refusal could have consequences for another individual, such as a fetus in utero.

2.14 **Special Consent Requirements** – The following procedures have specialized consent requirements under California land or Federal law:

a. **Blood transfusions** – Patients must be given (1) "A Patient's Guide to Blood Transfusion" whenever there is a reasonable possibility that an autologous transfusion may be needed and (2) allowed adequate time for pre-donation unless there are medical contraindications to pre-donation or the patient waives that right.

b. **HIV testing** – If a patient does not independently request an HIV test, prior to ordering one a medical care provider must make certain disclosures to the patient. The provider also must provide certain information and counseling when the test result is released to the patient. If a patient declines an HIV test that fact must be documented in the patient's medical record.

c. **Sterilization** - The Obstetric Gynecology Department, Family Medicine Department, and the Urology Division each have a policy regarding sterilization that includes appropriate informed consent in compliance with state and federal laws.

d. **Silicone Implants and Collagen Injections** - State law requires provision of specified information to patients prior to undergoing procedures that include the use of these materials.

e. **Vaccines** – Federal law requires the furnishing of written information before the administration of most vaccines. These statements can be found at www.immunize.org/vis

f. **Procedures related to research** - All research at RUHS is governed by the RUHS Institutional Review Board which may require completion of a specific informed consent form before a procedure relating to research is performed.

3. REFERENCES

3.1 The Joint Commission Comprehensive Accreditation Manual for Hospitals Standard RI.01.03.01.

3.2 California Hospital Association Consent Manual

3.3 Medical Informed Consent: General Considerations for Physicians, Paterick et al., Mayo Clin Proc. 2008;83(3):313-319

3.4 42 CFR Sec. 482.51(b)(2); Interpretive Guideline A-0392

Document History:

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Document Owner: Regulatory Compliance	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
6/13/2017	Policy Program Administrator	Y	Created new policy from CHA Consent Manual and the CAHM Manual
9/13/2017	Marty Knutson, Sunder Nambiar	Y	Revised and updated
9/2017	Chief Nursing Officer	Y	
9/2017	Director HIM	Y	
9/2017	Program Director, Surgery	Y	
9/2017	Chair, MEC	Y	
10/3/2017	Policy Approval Committee	Y	Minor wording

Informed Consent for Anesthesia and Surgery or Procedure at Riverside University Health System - Medical Center

Please read below before signing this form

Your doctor has recommended that you have the surgery or procedure(s) described on this form. Before you sign this form, please understand:

- Your doctor may need to do more than what is described on this form. This could happen if your doctor finds a serious, unexpected condition. This would happen if your doctor feels doing more will reduce harm to you and/or prevent a second procedure. By signing this form you are also giving permission for your doctor to do more, if necessary.
- Your doctor may be helped by other doctors and assistants. They may include doctors in training. They will be under your doctor's supervision.
- Tissue and specimens removed during surgery will be examined in the hospital's pathology department. After that, the tissue and specimens will be disposed of in a medically appropriate way.
- If you may require a blood transfusion during this surgery, your doctor will tell you about your options. One of these options may include donating your own blood before surgery. Another option may be directed donation, blood donated by people who you ask to donate for you. You have the right to refuse any transfusion.
- Any surgery can be unsuccessful. It can also have complications. No one can guarantee of the outcome of this surgery to you.
- You have the right to refuse any or all proposed surgery or procedure(s).

Licensed Physician(s) Performing Surgery / Procedure:

_____

_____

Surgery or Procedure(s) (including surgical site and laterality, if applicable):

_____

_____

Potential Risks:

_____

_____

Potential Benefits: _____

_____

Alternatives to Procedure(s): _____

_____

Performing Physician / Surgeon Certification and Patient Consent

I, the undersigned physician, hereby certify that:

- I have discussed the information contained in this consent form with this patient (or the patient's legal representative), answered any questions and received consent to the procedure(s) discussed.
- I also discussed any research or economic interest that I may have regarding this treatment.

Licensed Physician Signature	*Print Name*	*Date*	*Time*

The risks, benefits, and alternatives of the recommended procedure(s) have been explained to me and **I approve and direct that the listed procedure(s) be performed.**

Patient /Legal Representative's Signature	*Print Name*	*Date*	*Time*

Relationship to Patient

If Interpreter is required:

☐ Phone or Video Conference Interpreter

Interpreter's Signature or ID #	*Print Name*	*Language*

If consent is obtained by telephone or by video conference from a legal representative:

Name of Person Giving Consent	*Relationship to Patient*

Doctor / Witness Signature	*Print Name*	*Title*	*Date*	*Time*

Witness Signature	*Print Name*	*Title*	*Date*	*Time*

All forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results. ☐ General ☐ Monitored Anesthesia Care ☐ Spinal ☐ Epidural

☐ **Anesthesia Risks:**

Although they only happen rarely, complications can occur with anesthesia. These include:

Headache	Blood Clots
Eye Injury or Blindness	Awareness During the Procedure
Injury to your Mouth or Teeth	Injury to Blood Vessels
Hoarseness	Backache
Nausea	Infection
Vomiting	Loss of Sensation
Aspiration (Vomit, Blood or Mucus in your Lung)	Persistent weakness
Pneumonia	Numbness
Lung Collapse	Pain
Delirium	Memory Loss
Post-Cognitive Dysfunction	Loss of Limb Function
Hair Loss	Paralysis
Injury from Positioning	Stroke
Bleeding	Brain Damage
Drug Reactions	Heart Attack
Convulsions	Death

Sometimes local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia. Additional risks may apply.

☐ **Moderate or Deep Sedation Risks:** Pain, allergic reaction, respiratory compromise, aspiration prolonged response requiring longer observation, Intubation, arrhythmia, impaired motor coordination up to 24 hours, possible hospital admission, cardiac arrest and death.

Licensed Physician Signature	*Print Name*	*Date*	*Time*

The anesthetic / sedation plan, specific risks and anesthetic procedure(s) have been explained to me and **I approve to proceed as planned.**

Patient /Legal Representative's Signature	*Print Name*	*Date*	*Time*

If Interpreter is required:

☐ Phone or Video Conference Interpreter

Interpreter's Signature or ID #	*Print Name*	*Language*

If consent is obtained by telephone or by video conference from a legal representative:

Name of Person Giving Consent	*Relationship to Patient*			
Doctor / Witness Signature	*Print Name*	*Title*	*Date*	*Time*
Witness Signature	*Print Name*	*Title*	*Date*	*Time*

RIVERSIDE UNIVERSITY HEALTH SYSTEM- MEDICAL CENTER
HOUSEWIDE

	Document No: 626	Page 1 of 4
Title: Abuse, Neglect, and/or Domestic Violence Assessment and Reporting	**Effective Date:** 8/31/17	☑ Hospital-Wide ☐ Departmental
Approved By and Date Approved: Jennifer Cruikshank CEO/ Hospital Director		☐ Policy ☐ Procedure ☑ Guideline

1. DEFINITIONS

1.1 Mandated Reporting. "Any health practitioner employed in a health facility, clinic, physician's office, local or state public health department, or a clinic or other type of facility operated by a local or state public health department who, in his or her professional capacity or within the scope of his or her employment, provides medical services for a physical condition to a patient whom he or she knows or reasonably suspects is a [victim of abuse, neglect, or exploitation], shall immediately make a report" to the appropriate agency.[5.2]

1.2 Mandated Reporters. Include, but are not limited to: "A physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage and family therapist, clinical social worker, professional clinical counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code. An emergency medical technician I or II, paramedic, or other person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code. A psychological assistant registered pursuant to Section 2913 of the Business and Professions Code. A marriage and family therapist trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code. An unlicensed marriage and family therapist intern registered under Section 4980.44 of the Business and Professions Code. A state or county public health employee who treats a minor for venereal disease or any other condition."[5.3]

1.3 Reasonably Suspects. "It is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect."[5.4]

2. GUIDELINES

2.1 All RUHS - MEDICAL CENTER staff will, to the best of their ability, protect patients from real or perceived abuse, neglect, or exploitation from anyone, including staff, students, volunteers, other patients, visitors, family members, or strangers.

2.2 All allegations, observations, reports or suspected cases of abuse, neglect, domestic violence, or exploitation will be reported immediately to the appropriate agency (ies).

2.3 Obligation to Report:

a. Nothing in these guidelines should be interpreted to relieve the *Mandated Reporter* of his or her obligation to promptly report to authorities their reasonable suspicion that an individual (especially a child, elder, a dependent, a spouse, or a domestic partner) has been the victim of abuse or neglect as required under California law. *Mandated Reporters* may report independently of the hospital, with or without disclosing the fact of their report to hospital representatives.

2.4 Screening for Abuse or Neglect:

a. The suspicion that someone has been the victim of abuse or neglect is rarely based on a single observation or statement. For example, a patient's response to a question upon entrance to the organization (such as "do you feel safe at home?") is insufficient to conclude that the person may have been abused or neglected.

b. As with any diagnosis or assessed need, a reasonable suspicion of abuse or neglect is raised in the mind of the competent healthcare practitioner based on the patient's history and the integration of physical and psychological assessments and observations.

c. Therefore the hospital's approach to screening for abuse and neglect is embedded in the overall process of care and does not rely on the answer to a set of questions or a "screener's" conclusion at a single point in the healthcare process.

2.5 **Social Service Referral**

a. Patient and Family Services is a resource to hospital personnel and a department representative is on call at all times to 1) assist caregivers in their assessment of suspected abuse or neglect, and 2) for assistance in reporting and patient support.

2.6 **Documentation**

a. Any observations (including statements made by any individual) or clinical findings suggesting a patient may have been abused or neglected should be documented in their medical record.

b. However, a caregiver's conclusion as to the presence or absence of abuse or neglect should not be documented in the medical record unless the practitioner arrives at a diagnosis which, by definition, meets the legal definition of abuse or neglect.

2.7 **Internal Reporting**

a. Any RUHS- MEDICAL CENTER representative who suspects that a patient, staff member, or visitor is the victim of abuse or neglect should immediately report their suspicion through the chain of command verbally followed by the completion of an incident report using the Datix Incident Reporting System (http://datixapp01/datix/live/index.php).

b. Such internal reporting does not relieve the individual of any obligation he or she may have to report their suspicion to law enforcement authorities according to California law.

2.8 **Education**

All clinical employees should receive education (at the time of hire and regularly thereafter) about the criteria for identifying, and the procedures for handling, patients who injuries or illnesses are attributable to:

a. Spousal or partner abuse;

b. Elder or dependent abuse or neglect;

c. Sexual assault/ rape; or

d. Child abuse or neglect.

2.9 **Patient/ Family Education**

a. Patients exhibiting signs of spousal or partner abuse should be advised of crisis intervention services.

b. They should also be provided a list of private and public community agencies that provide, or arrange for, evaluation and care for persons experiencing spousal and partner abuse, including, but not limited to, hotlines, local shelters, legal services, and information about temporary restraining orders.

c. Such resource lists are maintained by Patient and Family Services, the Sexual Assault Response Team, The Child Abuse and Neglect Team, and shall be immediately available through the emergency department.

3. REFERENCES

3.1 The Joint Commission Comprehensive Accreditation Manual- Hospital 2016 Standards: RI.01.06.03: The patient has the right to be free from neglect; exploitation; and verbal, mental, physical and sexual abuse.

3.2 California Penal Code § 11160(a)

3.3 California Penal Code § 11165.7(a)

3.4 California Penal Code § 11162.5(d)

4. ATTACHMENTS

4.1 CalOES 2-920: California Suspicious Injury Report
http://www.caloes.ca.gov/GrantsManagementSite/Documents/2-920%20Mandated%20Suspicious%20Injury%20Report.pdf

4.2 RUHS - MEDICAL CENTER SART Intake Form

4.3 California Suspected Child Abuse Report
http://ag.ca.gov/childabuse/pdf/ss_8572.pdf

4.4 State of California- Health and Human Services Agency Report of Suspected Dependent Adult/ Elder Abuse (Form SOC 341)
www.cdss.ca.gov/cdssweb/entres/forms/English/SOC341.pdf

Subject: Abuse, Neglect, and/or Domestic Violence Assessment and Reporting	**Document No. 626**

Document History:

Release Dates: 04/01/90, 04/21/06,1/15/09	**Retire Date:** N/A
Document Owner: Regulatory Compliance	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made?	Revision Description
7-15-2016	Regulatory Compliance Patient & Family Services (Consulted) County Counsel (Consulted) Sexual Assault Response Human Resources Executive Management Medical Executive Committee	Yes	1. Revised language under policy 2. Removed procedure 3. Added new references
8/18/16	Policy Approval Committee	Yes	Format
8/22/16	Hospital Executive Committee	No	
8/23/2017	Regulatory and Accreditation	Yes	
8/23/2017	SART	No	
8/23/2017	ACNO for Trauma, ED, ICU	No	
8/31/2017	Policy Program Admin	No	

State of California
Office of Emergency Services
(www.oes.ca.gov)

MANDATED SUSPICIOUS INJURY REPORT

CAL OES 2-920

For copies of this form or assistance in completing the Cal OES 2-920, please contact the
California Clinical Forensic Medical Training Center:
(916) 930-3080 or
Contact Us @ www.ccfmtc.org

SUSPICIOUS INJURY REPORT

STATE OF CALIFORNIA
California Office of Emergency Services

Cal OES 2-920

Confidential Document

Penal Code Section 11160 requires that if any health practitioner, within their scope of their employment, provides medical services for a wound or physical injury inflicted as a result of assaultive or abusive conduct, or by means of a firearm, shall make a telephone report immediately or as soon as possible. They shall also prepare and submit a written report within 2 working days of receiving the information to a local law enforcement agency. This is the official form (Cal OES 2-920) for submitting the written report.

This form is used by law enforcement only and is confidential in accordance with Section 11163.2 of the Penal Code. In no case shall the person identified as a suspect be allowed access to the injured person's whereabouts.

Part A: PATIENT WITH SUSPICIOUS INJURY

1. Name of Patient (Last, First, Middle)	2. Birth Date	3. Gender ☐ M ☐ F	4. SAFE Telephone Number ( )
5. Patient Address (Number and Street / Apt – **No P.O. Box**)	City	State	Zip
6. Patient Speaks English ☐ Yes ☐ No If No, identify language spoken:_____	7. Date and Time of Injury Date:	Time: ☐ am ☐ pm ☐ unknown	
8. Location / Address Where Injury Occurred, if Available. Check here if unknown: ☐			
9. Patient description of the incident. Include any identifying information about the person the patient alleges caused the injury and the names of any persons who may know about the incident. ☐ Additional Pages Attached			
10. Name of Suspect, if Identified by the Patient	11. Relationship to Patient. ☐ No Relationship		
12. Suspicious Injury Description. Include a brief description of physical findings, lab tests completed or pending, and other pertinent information. ☐ Additional Pages			

Part B: REQUIRED – AGENCIES RECEIVING PHONE AND WRITTEN REPORTS

13. Law Enforcement Agency Notified By Phone (Mandated by PC 11160)	14. Date and Time Reported Date: Time: am pm	
15. Name of Person Receiving Phone Report (First and Last)	16. Title	17. Phone Number ( )
18. Law Enforcement Agency Receiving Written Report (Mandated by PC 11160)	19. Agency Incident Number	

Part C: PERSON FILING REPORT

20. Name of Health Practitioner (First and Last)	Title	Telephone
21. Employer's Name		Phone Number
22. Employer's Address (Number and Street)	City State	Zip
23. HEALTH PRACTITIONER'S SIGNATURE:		26. Date Signed:

Print

SUSPECTED CHILD ABUSE REPORT

Reset Form

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

PLEASE PRINT OR TYPE

CASE NAME: _____

CASE NUMBER: _____

A. REPORTING PARTY

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

B. REPORT NOTIFICATION

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

C. VICTIM
One report per victim

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

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

D. INVOLVED PARTIES

VICTIM'S SIBLINGS

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

VICTIM'S PARENTS/GUARDIANS

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

SUSPECT

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

E. INCIDENT INFORMATION

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

DATE / TIME OF INCIDENT	PLACE OF INCIDENT

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

SS 8572 (Rev. 12/02)

DEFINITIONS AND INSTRUCTIONS ON REVERSE

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

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

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

CONFIDENTIAL REPORT - NOT SUBJECT TO PUBLIC DISCLOSURE

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

DATE COMPLETED:

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

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

*NAME (LAST NAME FIRST)	*AGE	DATE OF BIRTH	SSN	GENDER	ETHNICITY	LANGUAGE (✓ CHECK ONE)
				☐ M ☐ F		☐ NON-VERBAL ☐ ENGLISH ☐ OTHER (SPECIFY)

*ADDRESS (IF FACILITY, INCLUDE NAME AND NOTIFY OMBUDSMAN)	*CITY	*ZIP CODE	*TELEPHONE
			( )
*PRESENT LOCATION (IF DIFFERENT FROM ABOVE)	*CITY	*ZIP CODE	*TELEPHONE
			( )

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

B. SUSPECTED ABUSER ✓ Check if ☐ Self-Neglect

NAME OF SUSPECTED ABUSER

☐ CARE CUSTODIAN (type)_____ ☐ PARENT ☐ SON/DAUGHTER ☐ OTHER_____

☐ HEALTH PRACTITIONER (type)_____ ☐ SPOUSE ☐ OTHER RELATION_____

ADDRESS	*ZIP CODE	TELEPHONE	GENDER	ETHNICITY	AGE	D.O.B.	HEIGHT	WEIGHT	EYES	HAIR
		( )	☐ M ☐ F							

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

*NAME (PRINT)	SIGNATURE	OCCUPATION	AGENCY/NAME OF BUSINESS

RELATION TO VICTIM/HOW KNOWS OF ABUSE	(STREET)	(CITY)	(ZIP CODE)	(E-MAIL ADDRESS)	TELEPHONE
					( )

D. INCIDENT INFORMATION - Address where incident occurred:

*DATE/TIME OF INCIDENT(S)

PLACE OF INCIDENT (✓ CHECK ONE)

☐ OWN HOME ☐ COMMUNITY CARE FACILITY ☐ HOSPITAL/ACUTE CARE HOSPITAL

☐ HOME OF ANOTHER ☐ NURSING FACILITY/SWING BED ☐ OTHER (Specify)

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

1. PERPETRATED BY OTHERS (WIC 15610.07 & 15610.63)

a. PHYSICAL
- ☐ ASSAULT/BATTERY
- ☐ CONSTRAINT OR DEPRIVATION
- ☐ SEXUAL ASSAULT
- ☐ CHEMICAL RESTRAINT
- ☐ OVER OR UNDER MEDICATION

b. ☐ NEGLECT
c. ☐ FINANCIAL
d. ☐ ABANDONMENT
e. ☐ ISOLATION
f. ☐ ABDUCTION
g. ☐ OTHER (Non-Mandated: e.g., deprivation of goods and services: psychological/mental)

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

a. ☐ PHYSICAL CARE (e.g., personal hygiene, food, clothing, shelter)
b. ☐ MEDICAL CARE (e.g., physical and mental health needs)
c. ☐ HEALTH and SAFETY HAZARDS
d. ☐ MALNUTRITION/DEHYDRATION
e. ☐ OTHER (Non-Mandated e.g., financial)

ABUSE RESULTED IN (✓ CHECK ALL THAT APPLY) ☐ NO PHYSICAL INJURY ☐ MINOR MEDICAL CARE ☐ HOSPITALIZATION ☐ CARE PROVIDER REQUIRED ☐ DEATH ☐ MENTAL SUFFERING ☐ OTHER (SPECIFY) ☐ UNKNOWN

F. REPORTER'S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. DOES ALLEGED PERPETRATOR STILL HAVE ACCESS TO THE VICTIM? PROVIDE ANY KNOWN TIME FRAME (2 days, 1 week, ongoing, etc.). *LIST ANY POTENTIAL DANGER FOR INVESTIGATOR (animals, weapons, communicable diseases, etc.).* ☐ ✓CHECK IF MEDICAL, FINANCIAL, PHOTOGRAPHS OR OTHER SUPPLEMENTAL INFORMATION IS ATTACHED)

G. TARGETED ACCOUNT

ACCOUNT NUMBER (LAST 4 DIGITS):	TYPE OF ACCOUNT: ☐ DEPOSIT ☐ CREDIT ☐ OTHER	TRUST ACCOUNT: ☐ YES ☐ NO
POWER OF ATTORNEY: ☐ YES ☐ NO	DIRECT DEPOSIT: ☐ YES ☐ NO	OTHER ACCOUNTS: ☐ YES ☐ NO

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

NAME	ADDRESS	TELEPHONE NO.	RELATIONSHIP
		( )	

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

*NAME

IF CONTACT PERSON ONLY ✓ CHECK ☐ *RELATIONSHIP

*ADDRESS	*CITY	*ZIP CODE	*TELEPHONE
			( )

J. TELEPHONE REPORT MADE TO: ☐ Local APS ☐ Local Law Enforcement ☐ Local Ombudsman ☐ Calif. Dept. of Mental Health ☐ Calif. Dept. of Developmental Services

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

K. WRITTEN REPORT Enter information about the agency receiving this report. Do not submit report to California Department of Social Services Adult Programs Bureau.

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

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

1. Report Received by: Date/Time:

2. Assigned ☐ Immediate Response ☐ Ten-day Response ☐ No Initial Face-To-Face Required ☐ Not APS ☐ Not Ombudsman

Approved by: Assigned to (optional):

3. Cross-Reported to: ☐ CDHS, Licensing & Cert.; ☐ CDSS-CCL; ☐ CDA Ombudsman; ☐ Bureau of Medi-Cal Fraud & Elder Abuse; ☐ Mental Health; ☐ Law Enforcement; ☐ Professional Board; ☐ Developmental Services; ☐ APS; ☐ Other (Specify) Date of Cross-Report:

4. APS/Ombudsman/Law Enforcement Case File Number:

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE
GENERAL INSTRUCTIONS

PURPOSE OF FORM

This form, as adopted by the California Department of Social Services (CDSS), is required under Welfare and Institutions Code (WIC) Sections 15630 and 15658(a)(1). This form documents the information given by the reporting party on the suspected incident of abuse of an elder or dependent adult. **"Elder,"** means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). **"Dependent Adult,"** means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age (WIC Section 15610.23). Dependent adult includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility (defined in the Health and Safety Code Sections 1250, 1250.2, and 1250.3).

COMPLETION OF THE FORM

1. This form may be used by the receiving agency to record information through a telephone report of suspected dependent adult/elder abuse. Complete items with an asterisk (*) when a telephone report of suspected abuse is received as required by statute and the California Department of Social Services.
2. If any item of information is unknown, enter "unknown."
3. Item A: Check box to indicate if the victim waives confidentiality.
4. Item C: Check box if the reporting party waives confidentiality. Please note that mandated reporters are required to disclose their names, however, non-mandated reporters may report anonymously.

REPORTING RESPONSIBILITIES

Mandated reporters (see definition below under "Reporting Party Definitions") shall complete this form for each report of a known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect, (self-neglect), isolation, and abandonment (see definitions in WIC Section 15610) involving an elder or a dependent adult. **The original of this report shall be submitted within two (2) working days of making the telephone report to the responsible agency as identified below:**

- The county Adult Protective Services (APS) agency or the local law enforcement agency (if abuse occurred in a private residence, apartment, hotel or motel, or homeless shelter).
- Long-Term Care Ombudsman (LTCO) program or the local law enforcement agency (if abuse occurred in a nursing home, adult residential facility, adult day program, residential care facility for the elderly, or adult day health care center).
- The California Department of Mental Health or the local law enforcement agency (if abuse occurred in Metropolitan State Hospital, Atascadero State Hospital, Napa State Hospital, or Patton State Hospital).
- The California Department of Developmental Services or the local law enforcement agency (if abuse occurred in Sonoma Developmental Center, Lanterman Developmental Center, Porterville Developmental Center, Fairview Developmental Center, or Agnews Developmental Center).

WHAT TO REPORT

Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment has observed, suspects, or has knowledge of an incident that reasonably appears to be physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect), or is told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, isolation, financial abuse, abduction, or neglect, shall report the known or suspected instance of abuse by telephone immediately or as soon as practicably possible, and by written report sent within two working days to the appropriate agency.

REPORTING PARTY DEFINITIONS

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

Care Custodian (WIC) "15610.17 'Care custodian' means an administrator or an employee of any of the following public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff: (a) Twenty-four-hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code. (b) Clinics. (c) Home health agencies. (d) Agencies providing publicly funded in-home supportive services, nutrition services, or other home and community-based support services. (e) Adult day health care centers and adult day care. (f) Secondary schools that serve 18- to 22-year-old dependent adults and postsecondary educational institutions that serve dependent adults or elders. (g) Independent living centers. (h) Camps. (i) Alzheimer's Disease Day Care Resource Centers. (j) Community care facilities, as defined in Section 1502 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code. (k) Respite care facilities. (l) Foster homes. (m) Vocational rehabilitation facilities and work activity centers. (n) Designated area agencies on aging. (o) Regional centers for persons with developmental disabilities. (p) State Department of Social Services and State Department of Health Services licensing divisions. (q) County welfare departments. (r) Offices of patients' rights advocates and clients' rights advocates, including attorneys. (s) The Office of the State Long-Term Care Ombudsman. (t) Offices of public conservators, public guardians, and court investigators. (u) Any protection or advocacy

GENERAL INSTRUCTIONS (Continued)

agency or entity that is designated by the Governor to fulfill the requirements and assurances of the following: (1) The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, contained in Chapter 144 (commencing with Section 15001) of Title 42 of the United States Code, for protection and advocacy of the rights of persons with developmental disabilities. (2) The Protection and Advocacy for the Mentally Ill Individuals Act of 1986, as amended, contained in Chapter 114 (commencing with Section 10801) of Title 42 of the United States Code, for the protection and advocacy of the rights of persons with mental illness. (v) Humane societies and animal control agencies. (w) Fire departments. (x) Offices of environmental health and building code enforcement. (y) Any other protective, public, sectarian, mental health, or private assistance or advocacy agency or person providing health services or social services to elders or dependent adults."

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

Officers and Employees of Financial Institutions (WIC) "15630.1. (a) As used in this section, "mandated reporter of suspected financial abuse of an elder or dependent adult" means all officers and employees of financial institutions. (b) As used in this section, the term "financial institution" means any of the following: (1) A depository institution, as defined in Section 3(c) of the Federal Deposit Insurance Act (12 U.S.C. Sec. 1813(c)). (2) An institution-affiliated party, as defined in Section 3(u) of the Federal Deposit Insurance Act (12 U.S.C. Sec. 1813(u)). (3) A federal credit union or state credit union, as defined in Section 101 of the Federal Credit Union Act (12 U.S.C. Sec. 1752), including, but not limited to, an institution-affiliated party of a credit union, as defined in Section 206(r) of the Federal Credit Union Act (12 U.S.C. Sec. 1786 (r)). (c)As used in this section, "financial abuse" has the same meaning as in Section 15610.30. (d)(1)Any mandated reporter of suspected financial abuse of an elder or dependent adult who has direct contact with the elder or dependent adult or who reviews or approves the elder or dependent adult's financial documents, records, or transactions, in connection with providing financial services with respect to an elder or dependent adult, and who, within the scope of his or her employment or professional practice, has observed or has knowledge of an incident that is directly related to the transaction or matter that is within that scope of employment or professional practice, that reasonably appears to be financial abuse, or who reasonably suspects that abuse, based solely on the information before him or her at the time of reviewing or approving the document, records, or transaction in the case of mandated reporters who do not have direct contact with the elder or dependent adult, shall report the known or suspected instance of financial abuse by telephone immediately, or as soon as practicably possible, and by written report sent within two working days to the local adult protective services agency or the local law enforcement agency."

MULTIPLE REPORTERS

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

IDENTITY OF THE REPORTER

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

FAILURE TO REPORT

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

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

GENERAL INSTRUCTIONS (Continued)

EXCEPTIONS TO REPORTING

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

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

Per WIC Section 15630(b)(4)(A), in a long-term care facility, a mandated reporter who the California Department of Health Services determines, upon approval by the Bureau of Medi-Cal Fraud and the Office of the State Long-Term Care Ombudsman (OSLTCO), has access to plans of care and has the training and experience to determine whether all the conditions specified below have been met, shall not be required to report the suspected incident of abuse:

(1) The mandated reporter is aware that there is a proper plan of care.
(2) The mandated reporter is aware that the plan of care was properly provided and executed.
(3) A physical, mental, or medical injury occurred as a result of care pursuant to clause (1) or (2).
(4) The mandated reporter reasonably believes that the injury was not the result of abuse.

DISTRIBUTION OF SOC 341 COPIES

Mandated reporter: After making the telephone report to the appropriate agency, the reporter shall send the original and one copy to the agency; keep one copy for the reporter's file.
Receiving agency: Place the original copy in the case file. Send a copy to a cross-reporting agency, if applicable.
DO NOT SEND A COPY TO THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES ADULT PROGRAMS BUREAU.

SART Intake Form

For patients 11 and older*

Please fill this portion out prior to contacting SART

Where did assault take place? _____

When did assault take place? _____

Have you made a police report? ☐ Yes ☐No

If so, which agency did you contact? _____

What is the name of the officer/ detective? _____

What is the case number? _____

If not, do you wish to make a police report? ☐ Yes ☐No (patient still entitled to SART exam)

Do you wish to have evidence collection exam? ☐ Yes ☐No (patient does not require SART)

**********TRIAGE**********

Are you having any pain or bleeding? ☐Yes* ☐No

Were you strangled/ choked? ☐Yes* ☐No

Are you pregnant? ☐Yes* ☐No

Do you wish to be seen by a physician prior to evidence collection? ☐Yes* ☐No

* ***These patients MUST be medically cleared prior to being seen by SART***

**********SART TRIAGE GUIDELINES**********

The following patients **MUST** be medically cleared prior to being seen by SART (per hospital policy and EMTALA)

- Patients who were strangled/ choked
- Patients who have not contacted law enforcement prior to presenting to ED
- Patients who arrive by ambulance
- Patients who complain of pain and/or bleeding (not related to menstruation)
- Patients who are intoxicated when they present to ED
- Patients who are pregnant
- Patient who report head trauma/ loss of consciousness
- All inmates (per the Prison Rape Elimination Act)
- **All patients under the age of 12**

*Please contact SART nurse (by paging via operators) as soon as patient presents to ED. Be advised that SART may not be immediately available. **All** SART patients must be fully registered and triaged.*

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 630	Page 1 of 6
Title: Restraints and Seclusion	**Effective Date:** 3/20/2018	☐ **RUHS – Behavioral Health** ☐ **RUHS – Care Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. DEFINITIONS

1.1 **Chemical Restraint** is the use of a medication used to restrict the patient's freedom of movement that is not a standard treatment for the patient's new or continuing medical or behavioral condition.

1.2 **Restraint** is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.

1.3 **Seclusion** is the involuntary confinement of a person alone in a room or an area from which the patient is physically prevented from leaving.

1.4 **Violent Behavior** is violent or self-destructive behavior that jeopardizes the immediate safety of the patient, a staff member or others.

1.5 **Non Violent Behavior** is the behavior that interferences with medical treatments, lifesaving interventions or ambulating before medically appropriate.

1.6 **Physical Restraint** is the use of a manual hold to restrict freedom of movement of all or part of a patient's body, or that restrict normal access to the patient's body and that is used as a behavioral restraint.

2. PROCEDURES FOR ALL RESTRAINT USAGE

2.1 Patients shall be restrained only when clinically justified for violent or non-violent behavior as defined above in 1.4 and 1.5 and in accordance with applicable state and federal statutes and regulations.

2.2 Indications:

a. Restraint or seclusion may be used when less restrictive means are not sufficient to protect the physical safety of patients, staff members or others.

b. Seclusion may only be used for the management of Violent Behavior as defined in 1.4 above.

2.3 Use of Antipsychotic Medications to Manage Violent Behavior: Antipsychotic medications shall be used in doses consistent with the community standard, to protect the patient or others and to allow the patient to more effectively interact with their environment. Such use is not considered Chemical Restraint. We do not use chemical restraints.

2.4 Initiation: Each episode of restraint or seclusion shall be initiated:

a. Upon the order of a physician who is responsible for the patient, or
b. By a trained registered nurse when he or she determines it is necessary when he or she determines it is necessary to protect the patient.
c. An order from a physician who is responsible for the patient shall be obtained as soon as clinically possible after such initiation.

2.5 Notification of the Attending Physician: If the restraint was not ordered by a physician with attending responsibility for the patient, an attending physician shall be notified that restraint was applied within 24 hours following initiation. Documentation anywhere within the medical record by an attending physician, whether or not it addresses restraint, is considered evidence that the physician was notified of the restraint episode.

2.6 PRN Orders: PRN orders for restraint or seclusion shall not be used.

3. RESTRAINT PROCEDURES FOR MANAGEMENT OF VIOLENT BEHAVIOR

3.1 Duration of Restraint/Seclusion Orders for Violent Behavior:

a. Orders for restraint or seclusion applied to manage Violent Behavior shall remain in effect until the patient's behavior or situation no longer requires restraint or seclusion, but no longer than:
   - 4 hours for adults 18 years of age or older;
   - 2 hours for children and adolescents 9 to 17 years of age; or
   - 1 hour for children 8 years of age or younger.
b. Should the initial need for restraint/seclusion for the management of violent behavior continue beyond 23 hours the following must occur:
   - An in-person evaluation by a responsible licensed independent practitioner with issuance of a new order.
   - The in-person evaluation and issuance of a new order is required every 24 hours the patient continues to require the restraint for management of violent behavior in addition to the hour limitations defined in 3.1.a.

3.2 Assessment and Monitoring of Restraint/Seclusion Used for the Management of Violent Behavior:

a. One-hour Face-to-face Assessment: A licensed independent practitioner shall perform a face-to-face assessment of the patient's physical and psychological status within one hour of the initiation of restraint or seclusion.
b. Monitoring: Restrained or secluded patients shall be subject to monitoring by individuals trained to do so.
c. Simultaneously restrained and secluded patients shall be continuously monitored through
   - Face-to-face observation by staff members or
   - Remote observation by staff members located near the patient who are viewing a simultaneous video image and audio signal of the patient.
d. Assessment: Assessments by a registered nurse or physician assistant or evaluations completed by a responsible physician shall occur as often as indicated by the patient's condition, behavior, and environmental considerations and observed at least once every fifteen minutes for safety by staff trained to do so.

4. RESTRAINTS PROCEDURES FOR THE MANAGEMENT OF NON-VIOLENT BEHAVIOR

4.1 Duration of Restraint/Seclusion Orders for **Non-Violent** Behavior:

a. Orders for restraint for the management of Non-Violent Behavior shall remain in effect until the patient's behavior or situation no longer requires restraint.

4.2 Assessment and Monitoring of Restraint/Seclusion Used for the Management of Non-Violent Behavior.

a. Restraint used for the management of Non-Violent Behavior shall be subject to ongoing monitoring and assessment as specified in the patient's plan of care. Monitoring and assessments shall occur at least every two hours.

4.3 Documentation of Monitoring:

a. Episodes of restraint and/or seclusion shall be documented as indicated on currently approved assessments, monitoring and ordering forms and electronic medical records.

4.4 Care Plan: The restrained or secluded patient's written plan of care shall be modified to address appropriate interventions implemented to assure the patient's safety and encourage the least restrictive means of protecting the patient.

5. REPORTING RESTRAINTS RELATED DEATH

5.1 Hospital personnel shall promptly contact hospital administration whenever a patient expires:

a. While restrained;
b. Within 24 hours after being released from restraint; or
c. As the result of a restraint-related condition within 7 days after restraint removal.

5.2 Designated hospital representatives shall notify the Centers for Medicare and Medicaid Services (CMS) Regional Office of such deaths within one business day of their discovery. Such notification shall be documented in the patient's medical record. EXCEPTION: Such deaths may be recorded in a log rather than being reported to CMS if a) the death was not a result of or related to the restraint and b) only soft wrist ties were used to restraint the patient most proximate to death.

6. REFERENCES

6.1 Attachment A, Examples of Restraints

6.2 Attachment B, Restraint and Seclusion Training Plan

Document History

Prior Release Dates: 3/1994, 8/2007, 12/2013, 10/2/2016	**Retire Date:** N/A
Document Owner: Restraints Committee	**Replaces Policy:** 630.1, 630.2, 630.3

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
12/20/2017	Nursing Policies and Procedures Committee	N	
1/8/2018	Policy Approval Committee	Y	Minor wording
2/8/2018	Medical Executive Committee	N	
3/12/2018	Hospital Executive Committee	N	

ATTACHMENT A

Examples of Physical Restraint

Device	Not Restraint	Restraint
Devices to protect the patient during a procedure or anesthesia	During a procedure or anesthesia.	Once the patient has recovered from anesthesia and devices are not removed
Side Rails	Used to keep the patient from **falling out of bed or with a specialty mattress**	Used to keep the patient from **getting out of bed.** (Order may be PRN)
Mittens	Not tied down. Allows use of hand / fingers.	Patient cannot flex fingers or does not have access to his / her body.
Arm Boards	To protect site of intravenous access.	If used to prevent the patient from having access to his or her body.
Adaptive Devices: Seat belts, waist belts, Geri chairs, etc.	The patient can remove the device (or remove themselves from the device) in the same manner in which it was applied (e.g. unlatching a seat belt, untying a knot, letting the side rail down)	The patient cannot easily remove the device. (Order for Geri-chair may be PRN)
Covered bed	Covered bassinet for infants or toddlers.	For adults to keep them from getting out of bed.
Protective interventions for infants, toddlers and pre- school children	Stroller safety belts; seat belts for high chairs; etc.	N/A
Holding the patient	Light touching during escort	Therapeutic hold
Holding to give medications or treatments	Voluntary	Forced (requires order)
Forensic Devices (handcuffs, shackles)	Used for patients in the direct custody of a law enforcement officer.	May not be used as a device for restraint

Examples of Seclusion

Not Seclusion	Seclusion
Confinement on a locked unit or ward where the patient is with others.	Confinement in a locked room apart from other patients
Having the patient agree to confine their movements to a room with an open door.	Physically preventing a patient from leaving an unlocked room
A "time out" in a quiet (unlocked) location.	Preventing a patient from leaving an unlocked room through intimidation.

Antipsychotic Medications Used to Manage Violent Behavior

Not Chemical Restraint	Chemical Restraint
Common use of medications, within the standard of care and practice, and well-documented by literature	Uncommon or outmoded use of medications for the management of behavior. Lack of documentation of the behaviors indicating the need for the medication. (Such use is generally prohibited.)
Order may be PRN	Orders may **not** be PRN
Order renewed as required in medication management policy.	Order renewed at least every 4 hours for adults, every 2 hours for adolescents, every 1 hours for children. (**One-time orders preferred**.)
Medication and dose are consistent with professional standards of practice.	
Used for the safety of patients or others and to help the patient more effectively interact with their environment.	
May NOT be used for staff convenience.	
Documentation describes the behavior supporting the use of the medication.	
Monitoring of vital signs appropriate for the potential sedating effects of the medication and dose.	

Attachment B
Restraint and Seclusion Training Plan

A. The restraint and seclusion training plan shall be based on the results of quality monitoring activities. Minimum training shall include:
   1. The policy requirements and education for licensed independent practitioners who order restraint or seclusion.
   2. The instruction and competency requirements of hospital staff who assess patients for restraint, determine that restraint is indicated, or who apply restraint including:
      a. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.
      b. The use of nonphysical intervention skills.
      c. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.
      d. The safe application and use of all types of restraint or seclusion used by the staff member, including training on how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia);
      e. Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
      f. Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, and vital signs.
      g. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic re-certification.
      h. Recognition of signs of physical and psychological distress for hospital staff that monitor restrained patients.
   3. Documentation requirements, including but not limited to the plan of care.

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 656	Page 1 of 6
Title: Screening, stabilizing treatment and transfer of patients with Emergency Medical Conditions	**Effective Date:** 9/5/2017	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank, CEO/ Hospital Director		☒ Policy ☐ Procedure ☐ Guideline

1) PURPOSE

To describe policies and procedures for emergency medical screening, stabilizing treatment and appropriate transfer of individuals that come to the Hospital's dedicated emergency departments.

2) DEFINITIONS

2.1 **Appropriate Transfer** means a transfer of an individual with an emergency medical condition to another acute care hospital in accordance with federal and state law.

2.2 **Hospital Capacity** means the ability of the Hospital to accommodate an individual requesting or needing examination or treatment. Capacity encompasses the number and availability of qualified staff, beds, equipment, medical specialties and the Hospital's past practices of accommodating additional individuals in excess of its occupancy limits.

2.3 **Central Log** means a log maintained by the Hospital listing each individual who comes to its dedicated emergency department(s) or any location on the Hospital property seeking emergency assistance and the disposition of each individual.

2.4 **Comes to a Dedicated Emergency Department** means an individual who—

a. Presents at the Hospital's dedicated emergency department and requests or has a request made on his/her behalf for examination or treatment for a medical condition, or a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition;

b. Presents on Hospital property other than a dedicated emergency department, and

(i) requests or has a request made on his/her behalf for examination or treatment for what may be an emergency medical condition, or

(ii) a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs emergency examination or treatment;

c. Is in a non-Hospital owned ground or air ambulance that is on Hospital property for presentation for examination or treatment for a medical condition at the Hospital's dedicated emergency department.

2.5 **Dedicated Emergency Departments**. The following departments of the Hospital are dedicated emergency departments:

a. Emergency Department
b. Labor & Delivery
c. Arlington ETS

2.6 **Emergency Medical Condition** means:

a. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:
   - Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
   - Serious impairment to bodily functions; or
   - Serious dysfunction of any bodily organ or part; or

b. With respect to a pregnant woman who is having contractions:
   - When there is inadequate time to effect a safe transfer to another hospital before delivery; or
   - The transfer may pose a threat to the health or safety of the woman or the unborn child.

2.7 **Hospital Property** means the entire main Hospital campus, including parking areas and structures that are located within 250 yards of the main buildings. Neither the Campus Professional Center (CPC) building nor the Education building are part of the Hospital's property for this purpose.

2.8 **Inpatient** means an individual who is admitted to the Hospital for purposes of receiving inpatient services with the expectation that he/she will remain at least overnight and occupy a bed, even though the individual may be later discharged or transferred to another facility and does not actually use a Hospital bed overnight.

2.9 **Labor** means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman undergoing contractions is in "labor" until a physician, certified nurse midwife or another qualified person acting within the scope of his/her practice (and the Medical Staff Bylaws), certifies that, after a reasonable period of observation, the woman is in false labor.

2.10 **Medical Screening Examination** means the process required to determine within reasonable clinical confidence, whether or not a patient has an emergency medical condition or a woman is in labor

2.11 **On-Call List** means the list of physicians who are "on-call" after the initial medical screening examination to provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition.

2.12 **Outpatient** means an individual who has begun to receive outpatient services as part of a scheduled encounter.

2.13 **Physician** means: (i) a doctor of medicine or osteopathy; (ii) a doctor of dental surgery or dental medicine; or (iii) a doctor of podiatric medicine; each acting within the scope of his/her respective licensure and clinical privileges.

2.14 **Physician Certification** means a written certification by the treating physician ordering a transfer and setting forth, based on the information available at the time of transfer, that the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of a woman in labor, to the unborn child, from effecting the transfer.

2.15 **Qualified Medical Person** means the individuals who are qualified to determine if person, based on a complete medical screening examination, has an emergency medical condition. At RUHS – Medical Center this determination can be made by:

a. A licensed physician;
b. A physician assistant practicing in the Emergency Department or in Labor and Delivery
c. A nurse practitioner practicing in the Emergency Department or in Labor and Delivery;

d. A registered nurse
operating under a standardized procedure within the Labor and Delivery Department

2.16 **Stabilized** means, with respect to an emergency medical condition, either:
a. That a patient's emergency medical condition has been resolved; or
b. That no material deterioration of the patient's condition is likely within reasonable medical probability, to result from or occur during a transfer to another Hospital or
c. In the case of a woman in labor, that the woman delivered the child and the placenta.

2.17 **Stable for Discharge** means a determination by the treating physician, within reasonable clinical confidence, that an individual has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient or later as an inpatient, provided the individual is given a plan for appropriate follow-up care with the discharge instructions. For the purpose of discharging an individual with psychiatric condition(s), the individual is considered to be stable for discharge when he/she is no longer considered to be a threat to himself/herself or to others.

2.18 **Transfer** means the movement of a patient to another acute care hospital at the direction of a physician on the Hospital's medical staff and with the agreement of the hospital to which the patient is being transferred.

2.19 **Triage** means a process to determine the order in which individuals will be provided a medical screening examination by a qualified medical person. Triage is not the equivalent of a medical screening examination and does not determine the presence or absence of an emergency medical condition.

3) **SCOPE**

3.1 **This policy applies to**:
a. An outpatient during the course of a scheduled visit;
b. An inpatient (including inpatients who are "boarded" in the dedicated emergency department waiting for an available bed);
c. An individual who presents to any off-campus department of the Hospital that is not a dedicated emergency department;

4) **POLICY**

4.1 **Signage.** The Hospital will post signage conspicuously in lobbies, waiting rooms, admitting areas and treatment rooms where examination and treatment occurs in the form required by law that specifies the rights of individuals to examination and treatment for emergency medical conditions and that the Hospital participates in the Medi-Cal program

4.2 **Central Log.** Each dedicated emergency department of the Hospital will maintain a central log recording the names of all individuals who come to the emergency department and whether the person refused treatment, was refused treatment by the Hospital or whether the individual was transferred, admitted and treated, stabilized and transferred or discharged. Each dedicated emergency department will establish its own central log procedure.

4.3 **On-Call Coverage.** The Hospital will maintain a list of physicians who are on-call to come to the Hospital to consult or provide treatment necessary to stabilize an individual with an emergency medical condition. The notification of an on-call physician will be documented in the medical record and any failure or refusal of an on-call physician to respond to call will be reported to the medical staff and in the clinical documentation sent to a subsequent hospital if that failure or refusal results in the transfer of the patient to another facility.

4.4 **Maintenance of Records.** Medical and other records related to this policy (such as transfer logs, on-call lists and changes to the on-call list and central logs) will be maintained in accordance with County of Riverside record-retention policies, but not less than five years.

4.5 **Reporting EMTALA Violations.**
The Hospital will report to CMS or the state survey agency if it has a reason to believe that it has received an individual who has been transferred in an unstabilized emergency medical condition from another acute care facility. All Hospital personnel who believe that an EMTALA violation has occurred will report the violation to the RUHS – Medical Center Compliance Officer.

4.6 **Retaliation.** The Hospital will not retaliate, penalize or take adverse action against any physician or qualified medical person for refusing to transfer an individual with an emergency medical condition that has not been stabilized, or against any Hospital employee for reporting a violation of EMTALA or state laws to a government enforcement agency.

4.7 **Medical Screening Examination**

a. A medical screening examination will be offered to any individual who comes to a dedicated emergency department. The medical screening examination includes ancillary services routinely available to the dedicated emergency department (including the availability of on-call physicians). The medical screening examination must be the same appropriate examination that the qualified medical person would perform on any individual with similar signs and symptoms, regardless of the individual's ability to pay for medical care.
b. The scope of the medical screening examination should reflect the presenting complaint and the medical history of the individual. The process may range from a simple examination (such as a brief history and physical) to a complex examination that may include laboratory tests, MRI or diagnostic imaging, lumbar punctures, other diagnostic tests and procedures and the use of on-call physicians.

4.8 **Authorizations, Insurance or Method of Payment**

a. The Hospital will provide a medical screening examination, and, as clinically indicated, initiate necessary stabilizing treatment, without first inquiring about an individual's method of payment or insurance status.
b. Prior Authorization. The Hospital will not seek, or direct an individual to seek, authorization from the individual's insurance company or health plan until the hospital has provided the medical screening examination and initiated any further examination and treatment that may be required to stabilize the emergency medical condition.

4.9 **Transfer of Individuals with an Emergency Medical Condition**

a. The Hospital will not transfer an individual with an unstabilized emergency medical condition unless either (a) the individual requests the transfer having been informed of the related risks or (b) a physician certifies that the medical benefits reasonably expected from the provision of treatment at the receiving facility outweigh the risks to the individual from the transfer.
b. **Requirements for an Appropriate Transfer.** An individual with an unstabilized emergency medical condition may be transferred only after:
    i. The Hospital provides medical treatment within its capacity to minimize the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;
    ii. The patient or a legal representative on the patient's behalf has consented to the transfer;
    iii. The medical record reflects the vital signs and condition of the individual at the time of the transfer;
    iv. The receiving facility has available space and qualified personnel for treatment of the individual; and the receiving facility and receiving physician's agreement to accept the individual and provide appropriate medical treatment is documented in the patient's record;
    v. A copy of all medical records available at the time of transfer related to the emergency medical condition, including (i) records related to the

individual's emergency condition; (ii) the individual's informed written consent to transfer (iii) the physician certification ; and (iv) the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment has been prepared; and

vi. Proper personnel and equipment, as well as necessary and medically appropriate life-support measures during the transfer has been obtained. The transferring physician is responsible to determine whether an individual is stabilized and the mode of transportation, equipment and personnel required for transfer

4.10 **Refusals**

a. A patient has the right to refuse necessary stabilizing treatment and further medical examination, as well as a transfer to another facility.

b. **Refusal of Medical Screening Examination**. If an individual leaves the Hospital before receiving a medical screening examination, either with or without notice to staff of his/her departure, staff should document the circumstances and reasons (if known) for the individual's departure and the time of departure in either the department's central log or in the individual's medical record if a record has been started.

c. **Refusal of Examination or Stabilizing Treatment**. If an individual who has received a medical screening examination refuses to consent to further examination or stabilizing treatment, the attending physician will offer the examination and treatment to the individual, inform the individual of the risks and benefits of the examination and treatment and request that the individual sign a form that he/she has refused further examination or treatment.

d. **Refusal of a Transfer**. If an individual refuses to consent to a transfer, the attending physician must inform the individual of the risks and benefits to the individual of the transfer and request that the individual sign a form that he/she has refused the transfer.

4.11 **Acceptance of Transfers**

a. The Hospital has the obligation to accept an appropriate transfer of an individual with an unstabilized emergency medical condition who requires specialized capabilities or facilities if the Hospital has the capacity to treat the individual.

5) REFERENCES

5.1 California Hospital Association Consent Manual, Chapters 5 and 9.

5.2 California Hospital Association EMTALA—A Guide to Patient Anti-Dumping Laws Manual.

5.3 Title 22, California Code of Regulations, Section 70717

5.4 Health and Safety Code 1317.3

5.5 42 CFR Subpart B, Section 489.2-489.29

5.6 42 U.S.C. Section 1395cc, 1395dd

Document History:

Prior Release Dates: 8/2011, 8/2014	**Retire Date:** N/A
Document Owner: Administration	Replaces Policy: 637 Transfers and Transfer Closures: Patients from Other Facilities to RCRMC 637.1 Recording Transfers of Patients and Inappropriate Transfers Received. 638 Emergency Medical Response to Off-Campus Facilities having a Potential Emergency Medical Condition Patient Presenting 639 Evaluation, Treatment, and Transfer of ED Patients 639.1 Physicians On Call to the ED 639.2 Emergency Medical Response to On Campus Call 250 Yard perimeter

Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
6/1/2017	Policy Program Administrator	Y	Started with CHA Sample Policy
6/1/2017	EMTALA Policy Task Force including Social Services, Case Management, Admitting, ED, Trauma, Quality, House Supervisor	Y	Specify designated Emergency Departments, request further refining definitions specific to hospital
6/9/2017	Labor and Delivery	Y	Would like to specify where to report violations.
6/12/2017	Regulatory Compliance	Y	Minor wording on audits
6/14/2017	Arlington Policy Committee	Y	Minor wording mistakes
6/16/2017	County Counsel	Y	Legal corrections and clarifications
7/20/2017	Policy Approval Committee	Y	Clarify who may conduct medical examination and what the perimeter emergency response will be.
8/1/2017	ACNO ED, Trauma, ACCU	N	
8/1/2017	Policy Approval Committee	Y	Approve with deletions of 4.7 and 4.12b. Refine definition of who may conduct exam.
8/10/2017	Medical Executive Committee	N	
9/5/2017	Hospital Executive Committee	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM
Housewide

	Document No: 701.1	Page 1 of 5
Title: Notification of Privacy Breaches	**Effective Date:** 10/10/2017	☐ RUHS – Behavioral Health ☒ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank, CEO/ Hospital Director		☒ Policy ☐ Procedure ☐ Guideline

1. DEFINITIONS

1.1 **Breach**: The acquisition, use or disclosure of protected health information (PHI) in any form or medium (e.g., written, verbal, electronic) in a manner not permitted under the Health Insurance Portability and Accountability Act (HIPAA), which compromises the security or privacy of the PHI maintained by RUHS. Breach excludes:

a. Any unintentional acquisition, access, use or disclosure of protected health information by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules at 45 CFR 164 Subpart E.

b. Any inadvertent disclosure by a person who is authorized to access PHI at a covered entity or business associate to another person authorized to access PHI at the same covered entity or business associate, or hybrid entity in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules at 45 CFR 164 Subpart E.

c. A disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

1.2 **Business Associates:** A person or entity, including their subcontractors, who provide certain functions, activities, or services for or to Riverside University Health System (RUHS), involving the use and/or disclosure of protected health information. This includes but is not limited to lawyers, auditors, third party administrators, healthcare clearing houses, data processing companies, billing companies, health information organizations, e-prescribing gateways, and other covered entities. A business associate is not a RUHS employee.

1.3 **Covered Entity**: A health plan, health care clearinghouse, or health care provider who transmits any health in electronic form in connection with a standard transaction under HIPAA. RUHS is a covered entity.

1.4 **Individually Identifiable Health Information**: Information that includes the following identifiers: Names, addresses, dates (e.g. birth/admit/discharge dates), ages over 89, telephone/fax numbers, email addresses, URLs, social security and medical record numbers, account numbers, license numbers, biometric

identifiers, full face photos or comparable images, any other unique identifying number, characteristic or code (e.g. birthmarks, tattoos, identifying anomalies).

1.5 **Personal Information (PI):** An individual's first name or first initial and last name in combination with any one or more of the following data elements, when either the name or the data elements are not encrypted: (a) Social Security Number; (b) driver's license number or California identification card number; (c) account number, credit or debit card number, in combination with any required security code, access code, or password that would permit access to an individual's financial account; (d) medical information; or (e) health insurance information.

1.6 **Protected Health Information (PHI):** Individually identifiable health information transmitted or maintained in any form or medium, including oral, written, and electronic. Individually identifiable health information relates to 1) the past, present, or future physical or mental health, or condition of an individual; 2) provision of health care to an individual; or 3) past, present, or future payment for the provision of health care to an individual. Information is considered PHI where there is a reasonable basis to believe the information can be used to identify a specific individual.

Protected health information does not include individually identifiable health information of persons who have been deceased for more than 50 years.

1.7 **Security Incident:** Attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

1.8 **Subcontractor:** A person to whom a business associate delegates a function, activity or service, other than in the capacity of a member of the workforce or such business associate.

1.9 **Treatment:** The provision, coordination, or management of healthcare-related services by one or more healthcare providers, including the coordination or management of healthcare by a healthcare provider with a third party; consultation between healthcare providers relating to a patient; or for the referral of a patient for healthcare from one healthcare provider to another.

1.10 **Workforce Member:** A regular employee, temporary assistance employee (TAP), per diem employee, contract employee, volunteer, trainee, residents, medical students, and/or any other persons whose conduct, in the performance of work for RUHS – Medical Center, is under the direct control of RUHS – Medical Center, whether or not they are paid by RUHS – Medical Center. Medical Staff members may also be part of the "workforce".

1.11 **Discovery of a Breach:** A breach shall be treated as discovered as of the first day on which such breach is known to RUHS.

2. POLICY

2.1 Determining If a Breach Occurred

a. It is the responsibility of all supervisors and employees to immediately report any suspected breaches, including any impermissible access, use or disclosure of information or any security incident that may have resulted in a breach to the Privacy Officer in the Compliance Department at (951) 486-4659. The Compliance Department will determine if a breach of information has indeed occurred.

b. All stolen and lost electronic devices shall be immediately reported to the Compliance Department.

c. Business associates must notify the Privacy Officer in the Compliance Department that an impermissible access, use, or disclosure of PHI or security incident, including a breach, has occurred.

d. Any inadvertent or unauthorized access, use or disclosure of information will be evaluated and analyzed by the Compliance Department to determine when individuals whose information was breached need to be notified.

2.2 Breach Notification Requirements

a. If the Compliance Department determines that a breach has occurred, RUHS must provide notification of a Breach of Unsecured PHI to affected individuals, the California Department of Public Health (CDPH), the Secretary of the United States Department of Health & Human Services, and in certain circumstances of breaches affecting more than 500 individuals, to the media.

Below is a summary of the required notifications that will be handled by the Compliance Department:

i. California Department of Public Health: Breaches shall be reported in writing to the CDPH within 15 business days of discovery.

ii. Law Enforcement Delay: If a law enforcement official provides RUHS with a written statement which: (i) states that a notification delay is necessary because notification would impede a criminal investigation or cause damage to national security; and (ii) specifies the time period for which the delay is required, RUHS will delay required notifications for the specified time period and will retain the written statement of the law enforcement official. If a law enforcement official provides RUHS with a verbal request to delay notification and states orally that the notification delay is necessary because notification would impede a criminal investigation or cause damage to national security, RUHS will document the verbal request and the identity of the law enforcement official. Required notifications will be delayed for a period of 30 days from the date the verbal request was received, unless a law enforcement official provides RUHS a written statement during that time. In the event no written request is received within 30 days, the delay will be lifted.

iii. Media Notice: If RUHS experiences a breach affecting more than 500 residents of a state or jurisdiction, in addition to notifying the affected individuals, RUHS is required to provide notice to prominent media outlets serving the state or jurisdiction. RUHS would provide this notification in the form of a press release to appropriate media outlets serving the affected area. Like individual notice, this media notification must be provided without unreasonable delay and in no case later than 60 days following discovery of a breach and must include the same information required for individual notice.

iv. Individual Notice: RUHS must notify affected individuals following the discovery of a breach of unsecured PHI. RUHS must provide the individual(s) notice in written form by first-class mail or by email if the individual requests notification by email. If RUHS has insufficient or

out-of-date contact information for 10 or more individuals, RUHS must provide substitute individual notice by providing the notice on the home page of the Web site for 90 days or by providing the notice in major print or broadcast media in the jurisdiction where the affected individuals likely reside. If RUHS has insufficient or out-of-date contact information for fewer than 10 individuals, RUHS may provide substitute notice by an alternative form of written, telephone, or other means of communication.

v. Unless subject to a delay by law enforcement, the individual notification must be provided without unreasonable delay and in no case later than 15 business days following the discovery of a breach and must include, to the extent possible:

- A description of the breach,
- A description of the types of information that were involved in the breach,
- The steps affected individuals should take to protect themselves from potential harm,
- A brief description of what RUHS is doing to investigate the breach, mitigate the harm, and prevent further breaches, as well as
- Contact information for individuals to ask questions or learn further information.

vi. Additionally, if a substitute notice is provided via web posting or major print or broadcast media, the notification must include a toll-free number that will remain active for 90 days for individuals to contact RUHS to determine if their PHI was involved in the breach. If the breach involves PI, then the notification will also address whether the notification was delayed as a result of a law enforcement investigation, and include the toll-free telephone numbers and addresses of the major credit reporting agencies, if the breach exposed a social security number, driver's license or California identification card number.

vii. If RUHS determines that urgent communication with the affected individual(s) is necessary to prevent imminent misuse of the affected individual's PHI, RUHS may contact the affected individual by telephone or email. All such communications shall be documented. Such telephone or email communications shall be in addition to the required written notification.

viii. Notice to United States Department of Health & Human Services: In addition to notifying affected individuals and the media, when appropriate, RUHS must notify the Secretary of the United States Department of Health & Human Services (Secretary) of breaches of unsecured protected health information. RUHS is required to provide this notification by submitting an electronic breach notification within 60 days after the end of each calendar year (prior to March 1) for breaches that affect fewer than 500 individuals. If a breach affects 500 or more individuals, RUHS must notify the Secretary by submitting an electronic breach notification form without unreasonable

delay and in no case later than 60 days following the breach, contemporaneously with the notice to the individual. All notification requirements will be handled by the Corporate Compliance Department.

ix. Notification by a Business Associate: If a breach of unsecured PHI occurs at or by a Business Associate, the Business Associate must notify RUHS without unreasonable delay and in no case later than 2 days following the discovery of the breach. To the extent possible, the business associate should provide RUHS with the identification of each individual affected by the breach, as well as any information required to be provided by RUHS in its notification to affected individuals. The notification will be provided in accordance with the requirements set forth above.

Document History:

Prior Release Dates: 9/23/2009, 7/2014, 10/2014	**Retire Date:** N/A
Document Owner: Corporate Compliance	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
May 2015; August 2016 September 2017	Department of Corporate Compliance	Yes	Minor formatting. Expanded application of policy to RUHS Care Clinics
9/27/2017	Policy Approval Committee	Yes	Formatting
10/10/2017	Hospital Executive Committee	No	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 738	Page 1 of 2
Title: Transportation of Protected Health Information	**Effective Date:** 3/20/2018	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☒ Policy ☐ Procedure ☐ Guideline

1. SCOPE

1.1 This document applies to all instances when protected health information (PHI) is transported for operational needs, from one location to another, within a Riverside University Health System (RUHS) location or to another offsite location.

1.2 This document does not apply to Release of Information. All Release of Information requests and functions shall be referred to the Medical Records Department.

2. DEFINITIONS

2.1 **Offsite location** refers to a location that is not within the same physical campus or facility. This includes RUHS and non-RUHS locations.

2.2 **Protected Health Information (PHI)** is verbal, written, or electronic information created or maintained by RUHS that identifies an individual patient. Patient PHI includes, but is not limited to:

a. The patient's presence or location at RUHS.

b. Demographic information, such as name, age, date of birth, address, telephone and/or fax number, email income, social security number, account number, driver's license number, health plan, and/or medical record number.

c. Information about the patient's medical condition, diagnostics/testing, treatment, and prognosis.

2.3 **Minimum Necessary Standard** when using or disclosing PHI, or when requesting PHI from others, RUHS must take reasonable steps to limit uses and disclosures of PHI to the "minimum necessary" to accomplish the intended purpose of the use, disclosure, or request. This standard does not apply to requests of PHI for treatment, or when the individual requests their PHI.

2.4 **Secure Area** is defined as a location within the office, department, or unit that is not accessible to the general public.

3. POLICY

3.1 Appropriate safeguards should be applied whenever business practices require that PHI be transported between RUHS areas or offsite.

3.2 The decision to transport PHI from one RUHS area to another or to an offsite location shall only be based on a business need.

3.3 Transportation of PHI should be limited to the "minimum necessary" to accomplish the sanctioned, envisioned purpose.

3.4 The workforce member is responsible for maintaining the privacy and security of all PHI they are transporting.

3.5 Healthcare items (e.g., specimens, slides, and medication bottles) labeled or marked with patient identifiers shall be safeguarded during transport by using covered bags, cases, or containers.

3.6 Documents containing PHI shall be safeguarded during transport by using an envelope or folder, or covered by a sheet or tarp when being transported in a cart.

3.7 When transporting, PHI shall be delivered directly to the intended recipient, department, or secure area.

3.8 Loss, theft, or tampering of PHI during transport shall be immediately reported to the department manager and to the Compliance Department.

3.9 When transporting PHI from one location to another, PHI must be safeguarded as described herein and shall not be left unattended in vehicles.

4. REFERENCES

4.1 45 C.F.R. § 164.530(c)(1)

4.2 45 C.F.R. § 160.103

Document History:

Prior Release Dates: N/A	**Retire Date:** N/A
Document Owner: Compliance Department	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made?	Revision Description
08/2017	Compliance Department	Yes	New document
09/2017	Compliance & Ethics Committee	No	
2/3/2018	Policy Approval Committee	Yes	Minor clarifying language
3/12/2018	Hospital Executive Committee	No	

RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER
Housewide

	Document No: 802	Page 1 of 4
Title: Medication Orders	**Effective Date:** 9/5/2017	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank, CEO/ Hospital Director		☒ Policy ☐ Procedure ☐ Guideline

1. DEFINITIONS

1.1 Hard Stop. Halts the progress of prescribing, dispensing, or administering a medication that would likely be dangerous to a patient. Action must be taken to continue, e.g. change the order, or make a clarification. May apply to actions of clinical staff, or to disposition of medication orders.

1.2 Medication. Includes prescription medication, vitamins, nutraceuticals, vaccines, over-the-counter drugs, diagnostic and contrast agents, radioactive isotopes, respiratory therapy treatments, parenteral nutrition, blood derivatives, intravenous solutions, and any product designated by the Food and Drug Administration as a drug.

1.3 LIP. Licensed independent practitioner.

1.4 RUHS – Medical Center. Riverside University Health System – Medical Center, or simply "Medical Center".

1.5 DEA. United States Drug Enforcement Agency.

2. RESPONSIBILITIES

2.1 The hospital Medical Director will ensure compliance to this procedure.

2.2 LIPs who administer, prescribe, or dispense any controlled substance will:

a. Register with the DEA.

b. Renew DEA registration every three years.

c. Maintain the certificate of registration at the registered location and available for official inspection.

2.3 Clinical staff shall:

a. Use a HARD STOP when reviewing orders and question any medication order that does not seem appropriate to the patient's condition.

b. Be empowered to "STOP" the process until resolution is achieved,

c. Follow the chain of command in resolving medication order inconsistencies or errors.

3. POLICY

3.1 Order only medications needed to treat the patient's condition.

3.2 Issue clear, accurate, complete, and legibly written medication orders to eliminate ambiguity regarding the order.

3.3 A complete medication order contains:

a. Name of patient, AND either medical record number OR date of birth
b. Name of medication
c. Dose
d. Strength
e. Units (metric)
f. Route
g. Frequency
h. And rate; if applicable.

3.4 As needed (PRN) orders require an indication and frequency for completion.

3.5 Hold orders: will be treated as "discontinue" orders.

3.6 Resume orders: must be re-written as a new order with all required elements.

3.7 Titrating orders: must include the initial and maximum dose, incremental dosage change in response to the patient's status, and frequency of titration.

3.8 When ordering medications, overlapping and duplicate orders should be discontinued.

3.9 Herbal products will NOT be ordered.

3.10 Maintain a defined process for supervision of physician residents and medical students in compliance with regulatory standards.

3.11 Controlled Substances

a. Only providers authorized by the DEA, as indicated by the use of the DEA number, shall write orders for discharge prescriptions of controlled substances to be filled outside of the Medical Center.
b. Medication orders for Schedule II-V controlled substances must be compliant with current requirements issued by federal (DEA), and state Board of Pharmacy regulations.

3.12 Other Medications (Non-Controlled)

a. All LIPs may order non-controlled medications without co-signature or additional authorization.
b. Unlicensed physicians (residents, and trainees) may write orders for medications; these orders must be co-signed or authorized by a supervising LIP.
c. Medical and Physician Assistant (PA) students may scribe medication orders but these orders must be signed by a LIP.

3.13 Physician Assistant (PA) Drug Orders

a. PAs may issue drug orders only with licensed physician supervision and as described in their privileging.
b. Medication orders may be based on either a written formulary, practice-specific, and protocols that specify all criteria for use of a particular drug or device and any contraindications for the selection prepared by the supervising physician or must be approved by the supervising physician before it is filled.

- **Drugs listed in the protocol may include only drugs appropriate for use in the types of practice engaged in by the supervising physician and must be limited to a reasonable** quantity consistent with customary medical practice in the supervising physician's practice.

3.14 Advance Practice Nurse (APN) Medication Orders: APNs may furnish/prescribe/dispense medications per Nursing policies and procedures.
Abbreviations and Use of Decimals

Use of certain abbreviations and decimals is prohibited in order to minimize medication errors, and is described in other policy.

3.15 Use of Ranges: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or patient's status are not allowed.

3.16 Clarification of an Unclear Order: If a medication order is received that is unclear incomplete, unacceptable or illegible, the prescriber will be contacted for clarification prior to filling the order.

3.17 Use of Pre-Printed Medication Orders / Order Sets: Pre-printed medication order sets may be used and must be authorized by a LIP for a patient.

3.18 Standing Orders: Standing medication orders are those that indicate medications that can be initiated before the LIP creates the patient-specific order.

3.19 Generic or Brand Names in Medication Orders

a. Generic medication names should be used in orders. A brand or trade name may be included for clarification.
b. The hospital formulary establishes guidance on the use of generic medication names, and the use of generic drug substitution to fulfill a medication order.

3.20 Blanket Reinstatement: Blanket reinstatement of previous orders (a summary order to resume all previous orders) for medications is not allowed.

3.21 Chart Documentation: For each medication ordered, there must be a documented diagnosis, condition, or indication-for-use in the patient's medical record. Indication-for-use becomes part of the prescription when the patient needs to know that the medication is to be taken only on an as-indicated basis; i.e. for pain, etc.

3.22 Weight-Based Dosing: Medication orders requiring weight-based dosing shall include the patient's weight in kilograms (kg) and pertinent dosing parameters.

3.23 Pharmacist Review of Medication Orders: Pharmacists will review medication orders and contact the prescriber if questions arise.

3.24 Verbal/Telephone Order Authentication: Verbal/telephone orders must be dated, timed, and signed by physicians within 48 hours as per medical staff bylaws and Medical Center policy.

3.25 Written Order Error: Writing over a written order to correct it is NOT permitted. The erroneous order must be lined through, initialed, dated, and timed. The correct order then can be written in the chart.

3.26 Prescription Blanks: To avoid the risk of forgery the following precautions will be taken:

a. Keep prescription pads in a secured area at all times.
b. Never sign prescription blanks in advance.
c. Use prescription blanks ***only*** for writing prescriptions.

4. REFERENCES

4.1 § 482.23(c) Condition of Participation: Nursing Services

4.2 § 482.24(c) Condition of Participation: Medical Record Services

4.3 § 482.25(a) Condition of Participation: Pharmacy Services

4.4 The Joint Commission, Comprehensive Accreditation Manual for Hospitals

4.5 California Business and Professions Code, Section 2826-2836.3

Document History:

Prior Release Dates: 1/2002, 9/2008, 5/2012, 4/2013	**Retire Date:** N/A		
Document Owner: Pharmacy Department	**Replaces Policy:** N/A		
Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
03/14/2017	Pharmacy Review Committee	Yes	Removed sections related to unlicensed physician scribing and prescribing due to EHR and e-prescribing. Updated all RCRMC references to RUHS. Streamlined language throughout. Removed "do not use abbrev" list – it is part of policy 601.7. Updated 3.22 for weight based dosing in kg.
5/1/17	P&T	No	
5/18/2017	PAC	Yes	Minor reference change
6/8/2017	MEC	No	
9/5/2017	HEC	No	

RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER
Housewide

Title: 340 B Program Compliance and Drug Pricing	**Document No:** 850	Page 1 of 15
	Effective Date: 3/15/2017	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Zareh Sarrafian, CEO/ Hospital Director		☒ Policy ☐ Procedure ☐ Guideline

1. DEFINITIONS

1.1 RUHS – Medical Center. Riverside University Health System – Medical Center, or simply 'the Medical Center'.

1.2 All other Definitions/glossary of terms are be found in Appendix A.

2. 340B POLICY STATEMENTS. As a participant in the 340B Drug Pricing Program, the Medical Center's policies are:

2.1 Medical Center uses any savings generated from 340B in accordance with the 340B Program Intent. See Appendix B.

2.2 Medical Center meets all 340B Program eligibility requirements.

- Medical Center's OPA Database covered entity listing is complete, accurate, and correct, including NPI and MediCal billing numbers. See Appendix C, and C1.
- Medical Center is owned and operated by the County of Riverside, California.
- From the most recently filed Medicare cost report as certified during the most recent HRSA/OPA recertification period, Medical Center had a disproportionate share adjustment percentage greater than 11.75 percent. CMS Cost Report Worksheet E Part A line 33. See Appendix D.
- Medical Center does not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement, except in the following situations:
  a. Hospital cannot access a drug at the 340B price or WAC price to prevent disruptions in patient care.
- Medical Center uses 340B program drugs only within the four walls of the parent entity and/or within the outpatient clinics that are registered on the OPA database and fully integrated into the hospital and reimbursable on the most recently filed cost report. See Appendix E and Appendix F for a schedule of all outpatient reimbursable clinics.
- See Appendix F1 for the finalized signature block.

2.3 Medical Center complies with all requirements and restrictions of Section 340B of the Public Health Service Act and any accompanying regulations or guidelines including, but not limited to, the prohibition against duplicate discounts/rebates under Medicaid, and the prohibition against transferring drugs purchased under the 340B program to anyone other than an eligible patient of the entity.

2.4 Medical Center maintains auditable records demonstrating compliance with the 340B requirement described in the preceding item 2.3.

- Prescriber is on the hospital's eligible prescriber list as employed by or under contractual agreement with Riverside University Health System - Medical Center, and the individual receives a health care service from this professional such that care remains under the control of Medical Center. 340B drugs are used in outpatient facilities that appear as reimbursable on the most recently file CMS cost report and are registered on the OPA database or are located within the four walls of the parent. See Appendix G.
- Medical Center maintains records of the individual's health care using an Admission-Discharge-Transfer system, unique patient medical record numbers, and care records See Appendix H.
- The individual is an outpatient at the time medication is administered or dispensed. See Appendix H1.
- Medical Center does not purchase covered outpatient drugs for its outpatient registered facilities using a GPO.
- Medical Center bills Medicaid for 340B program drugs at the 340B cost (carve-in) and has registered accordingly on the OPA database.
    a. Medical Center will inform OPA immediately of any changes to its information on the OPA website/Medicaid Exclusion File.
    b. Medicaid (MediCal) reimburses for 340B drugs per California state regulation. See Appendix I.

2.5 Medical Center has systems/mechanisms and internal controls in place to reasonably ensure ongoing compliance with all 340B requirements.

2.6 Medical Center has an internal audit plan adopted by the 340B Oversight Committee and conducted periodically and annually as described in the audit plan. See Appendix J.

2.7 Medical Center uses contract pharmacy services, and the contract pharmacy agreement is performed in accordance with HRSA requirements and guidelines including, but not limited to, that the hospital obtains sufficient information from the contractor to ensure compliance. with applicable policy and legal requirements, and the hospital has utilized an appropriate methodology to ensure compliance.

- Signed Contract Pharmacy Services Agreement(s) complies with 12 contract pharmacy essential compliance elements. See Appendix K.

2.8 Medical Center acknowledges its responsibility to contact HRSA as soon as reasonably possible if there is any change in 340B eligibility or material breach by the hospital of any of the foregoing policies.

2.9 Medical Center elects to receive information about the 340B Program from trusted sources including, but not limited to:

- HRSA and OPA
- The 340B Prime Vendor Program, managed by Apexus

3. **RESPONSIBLE STAFF, COMPETENCY, LEADERSHIP.** The following Medical Center staff are engaged with 340B program compliance and are trained on the 340B program as noted:

3.1 Pharmacy staff: complete initial basic training via webinar on the 340B Prime Vendor Programs; additional competency and training is completed annually. Attendance at an Apexus 340B University Course for key staff involved with the 340B program.

3.2 Medical Center 340B Oversight Committee: complete initial basic training via webinar on the 340B Prime Vendor Programs, and participate in ongoing competency and training throughout the year during the Committee meetings.

3.3 The Medical Center 340B Oversight Committee has ultimate responsibility for the Medical Center 340B program This committee is comprised of key members from the following areas:

- Hospital Administration
- Finance
- Medical Records
- Patient Billing
- Hospital Information Technology
- Clinic/Ambulatory Administration
- Compliance
- Pharmacy
- County Counsel
- Deputy County Executive Officer

3.4 The 340B Oversight Committee meets no less frequently than on a quarterly basis and is charged with the following objectives:

- Determine strategy and assess related policies and procedures.
- Establish an audit structure for internal audits completed by Medical Center, as well as audit structure for external audits, which are completed annually, per OPA guidelines.
- Review the results of audits and take action as needed.
- Maintain standards for best practices, which may include sending key personnel to related conferences and/or training programs.
- Review and maintain current 340B standards per direction from HRSA, the OPA and Apexus.

- Ensure compliance and provide related oversight.
- Ensure needed resources for program administration.
- Assess programmatic modification or expansion of the 340B program.
- Correct and/or report programmatic deficiencies within expected timeframes.
- Discrepancies are immediately corrected and reported to the 340B Oversight Committee. Any significant discrepancies are documented, corrected, and discussed with the 340B Oversight Committee.
- Ensure 340B related records and transactions are maintained for a period of five years in a readily retrievable and auditable format.
- Review the 340B cost savings report.

3.5 The 340B Oversight Committee reports to Compliance Oversight Committee at least annually.

3.6 340B program leadership and responsibilities: Chief Operating Officer (COO):

- Principal officer in charge for the compliance and administration of the program.
- Attesting to the compliance of the program through the annual recertification process.
- Serves as the Authorizing Official.

3.7 340B program leadership and responsibilities: Chief Financial Officer (CFO):

- Communication of changes to the Medicare Cost report regarding clinics or revenue centers listed on the cost report.

3.8 340B program leadership and responsibilities: Director of Pharmacy:

- Accountable agent for 340B compliance.
- Agent of the COO and CFO to administer the 340B program to fully implement and optimize appropriate savings and ensure current policy statements and procedures are in place to maintain program compliance.
- Serves as the Primary Contact for HRSA.
- Maintains knowledge of the policy changes that impact the 340B program which includes, but not limited to, HRSA rules and Medicaid changes.
- Must coordinate timely communication of any change in clinic eligibility/information.

3.9 340B program leadership and responsibilities: Pharmacy 340B Coordinator:

- Provides day-to-day oversight of the program.
- Maintenance and testing of tracking software.
- Documentation of policy and procedures.

- Maintain system databases to reflect changes in the drug formulary or product specifications.
- Assure appropriate safeguards and system integrity.
- Assure compliance with 340B program requirements of qualified patients, drugs, providers, vendors, payors, and locations.
- Prepare 340B cost savings report detailing purchasing, replacement practices, and dispensing patterns demonstrating savings associated with the program.
- Monitor ordering processes, integrating most current pricing from wholesaler, and analyze invoices, shipping, and inventory processes.
- Support the Pharmacy software selection of tracking software to manage the 340B program.
- Archive the data so as to be available to auditors when audited.

3.10 340B program leadership and responsibilities: Pharmacy Buyers:

- Establish three distribution accounts and maintains those accounts; i.e. WAC account, 340B replenishment account, GPO account at each ordering location.
- Establish and maintain direct (non-wholesaler) accounts for GPO ("own use") class of trade as well as direct 340B accounts.
- Ordering all drugs from the specific accounts as specified by the processes employed.
- Continuously monitor product minimum/maximum levels to effectively balance product availability and cost-effective inventory control.
- Manage purchasing, receiving, and inventory control processes.

3.11 340B program leadership and responsibilities: Compliance Officer:

- Notify OPA if the 340B Oversight Committee determines that a material breach has occurred.

3.12 340B program leadership and responsibilities: Director of Revenue Cycle:

- Communication of all changes to Medicaid reimbursement for pharmacy services/products that impact 340B status.
- Modeling all managed care contracts (with/without 340B).
- Engage pharmacy in conversations that impact reimbursement.

3.13 340B program leadership and responsibilities: Pharmacy Informatics:

- Define processes and access to data for compliant identification of outpatient utilization for eligible patients.
- Maintain pharmacy components of the formulary database, product specifications, and descriptions.

4. 340B ENROLLMENT, RECERTIFICATION, CHANGE REQUESTS

4.1 Recertification Procedure. HRSA requires entities to recertify their information as listed in the OPA database annually. The Medical Center COO annually recertifies Medical Center's information by following the directions in the recertification email sent from the OPA to the COO by the

requested deadline. If specific recertification questions arise, OPA will be contacted at: 340b.recertification@hrsa.gov.

4.2 Enrollment Procedure: New Clinic Sites. The Medical Center staff evaluates a new service area or facility to determine if the location is eligible for participation in the 340B Program.

- The criteria used include: service area must be fully integrated into Medical Center and appear as a reimbursable clinic on the most recently filed cost report.
- If a new clinic meets these criteria, the Medical Center Authorizing Official approves the online registration process during the next quarterly registration window (January 1– January 15 for an effective start date of April 1; April 1– April 15 for an effective start date of July 1; July 1–July 15 for an effective start date of October 1; and October 1– October 15 for an effective start date of January 1). This includes submitting cost report information as required by OPA.

4.3 Enrollment Procedure: New Contract Pharmacy(ies):

- Medical Center ensures a signed contract pharmacy services agreement, containing the 12 essential compliance elements in the Contract Pharmacy Guidance, is in place between the entity and contract pharmacy. Medical Center's legal counsel reviews the contract and verified that all Federal, State, and local requirements have been met.
- Medical Center Authorizing Official completes the online process during the registration window (January 1–January 15 for an effective start date of April 1; April 1– April 15 for an effective start date of July 1; July 1–July 15 for an effective start date of October 1; and October 1– October 15 for an effective start date of January 1).
- The Pharmacy Director ensures that the Contract Pharmacy Registration Form is submitted via the online registration system.
- The Authorizing Official approves or denies all submissions electronically.
- The Pharmacy Director begins the contract pharmacy arrangement only on or after the effective date shown on the OPA website.

4.4 Changes to the Medical Center's Information in OPA Database:

- It is Medical Center's ongoing responsibility to immediately inform OPA of any changes to its information or eligibility. If Medical Center becomes aware that it loses eligibility, it will notify OPA immediately and stop purchasing drugs from the 340B program.
- An online change request will be submitted to OPA by the COO for changes to Medical Center's information outside of

the annual recertification timeframe. Change form will be submitted to OPA as soon as Medical Center is aware of the need to make a change to its database entry. Types of requests handled through a change form include but are not limited to:

a. Changes to entity contact information.
b. Adding a shipping address.
c. Changes to Medicaid Provider Number/NPI or Medicaid billing decisions.
d. Changes to existing contract pharmacy information.

5. PRIME VENDOR PROGRAM (PVP) ENROLLMENT, UPDATES

5.1 Medical Center is enrolled in the Prime Vendor Program.

5.2 Medical Center reviews and updates the profile as needed.

6. 340B PROCUREMENT, INVENTORY MANAGEMENT, DISPENSING.

6.1 340B inventory is procured and managed in the following settings:

- Outpatient Retail Pharmacy.
- Hospital, mixed-use, including outpatient infusion center (OPI).
- Hospital-based clinics.

6.2 Outpatient Retail Pharmacy

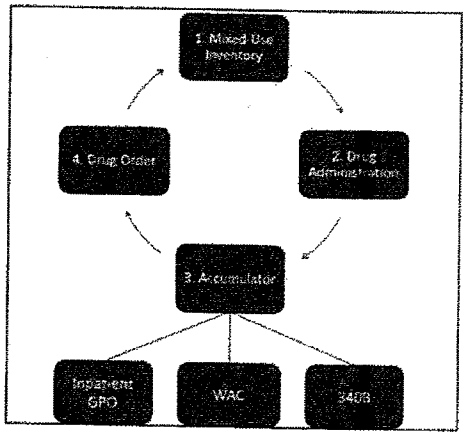
- Medical Center maintains a virtual 340B inventory.
- Pharmacy management software: Foundation Systems Inc. (FSI®).
- Medical Center utilizes the 340B split billing software, Verity AutoSplit 340B (previously known as Talyst).
- Medical Center utilizes the pharmaceutical wholesaler AmeriSourceBergen® (ABC) for the majority of drug purchases.
- Prior to filling any prescription, staff validate patient 340B eligibility by validating that the patient is eligible, seen at an eligible site, and that the prescriber is a physician or other prescribing allied health professional on staff at Medical Center.
- If the prescription is 340B eligible, the staff selects a corresponding eligible site code of prescription origin within FSI. The site code remains associated with the prescription for subsequent dispensing or refills.
- On a daily basis prescription dispensing data from FSI® is retrieved by Verity via switch.
- Verity receives a monthly secure file transfer of the hospital provider database, which is maintained by credentialing. See Appendix G.

- Verity receives a daily secure file transfer of the patient registration system.
- Verity uses the FSI data, the provider data, and the patient registration data to identify 340B qualified prescriptions.
    a. These 340B qualified prescriptions that were dispensed accumulate to 340B purchases.
- The pharmacy, when placing replenishment orders, uses AutoSplit so that previously dispensed 340B qualified medications are bought on a 340B account. All other purchases default to WAC.
    a. Order will be placed on 340B account if enough dispensing units have accumulated to purchase a wholesale package unit.
- Upon receipt of the wholesaler orders, staff examines the order against the invoice and reports inaccuracies to ABC. WAC inventory is identified by affixing the wholesaler pricing sticker.
- 340B inventory is stored in the outpatient pharmacy maintained with a security system. Only pharmacy employees have access to the pharmacy through a bar-coded, badge-ID limited entry system.
- If a prescription is originally filled with a 340B drug, subsequent refills of the outpatient prescription may be filled with 340B drugs for up to one year from the original fill date as such refills are considered part of the same continuum of care as the hospital services that gave rise to the original prescription.
- If it is identified that a prescription was filled errantly with 340B inventory, it is reprocessed, and 340B accumulation is removed.
    a. For example, if 340B Humira inventory is prescribed by a non-qualified RUHS-MC prescriber, then Humira's 340B accumulation is decremented. If such a correction creates a negative accumulation the next ordered dose of Humira will be ordered at WAC price, which balances the transaction.

6.3 Hospital, Mixed-use areas including OPI.

- Medical Center maintains a virtual 340B inventory.
- Pharmacy management software: Siemens Pharmacy.
- Medical Center utilizes split-billing software: Verity AutoSplit 340B.
- Medical Center utilizes pharmaceutical wholesaler AmeriSourceBergen® (ABC) for the majority of drug purchases.
- Medical Center utilizes a web-based application from ABC for ordering: Passport Punch-out.
- Medical Center uses a replenishment model.

- Sample Standard process is illustrated below:



1. Purchase mixed-use inventory according to eligible accumulations; an initial purchase of an 11 digit NDC will be purchased on WAC account
2. Administer/dispense drugs to patients.
3. Accumulator accumulates drug on an 11-digit NDC match until unit of use is met, prepares order, uses patient/clinic/prescriber information to determine the appropriate contract for ordering.

GPO	WAC	340B
Inpatient status determined by hospital at the date/time of administration.	Non 340B eligible patients, and Products that: • Do not have an 11 digit NDC match on the 340B contract • Have new NDCs • Are requested to purchase in excess of currently accumulated levels • Can no longer be replenished at the 11-digit NDC level	Patients met 340B patient definition and received services on an outpatient basis in a 340B eligible hospital mixed use area or clinic

4. Replenishment drug order(s) are placed.

- RUHS-MC staff places 340B orders to the wholesaler via a web-based application, based upon orders created from the Verity AutoSplit 340B software. When the product is purchased, the accumulator is automatically decremented.
- For direct purchases, RUHS-MC staff places orders based on data found on the Verity accumulator or by contacting our 340B Verity Solutions Account Manager. If there are sufficient credits available, and the manufacturer offers 340B pricing, then the purchase is made on the 340B direct account. For direct accounts the accumulator is adjusted manually.
- Detailed operation of the AutoSplit 340B split-billing software can be found in the AutoSplit 340B training manual. AutoSplit 340B workflow summaries are in Appendix M.
- Medical Center staff maintains records of 340B related transactions for a period of five years in a readily retrievable and auditable format.

- Upon receipt of the wholesaler orders, staff examines the order against the invoice and reports inaccuracies to ABC. WAC inventory is identified by affixing the wholesaler pricing sticker.
- 340B inventory is stored in the inpatient pharmacy maintained with a security system. Only pharmacy employees have access to the pharmacy through a bar-coded, badge-ID limited entry system.

6.4 Hospital Based Clinics, within four walls, not Mixed-use.

- Medical Center operates hospital based clinics, and provides care by eligible providers to 340B eligible patients including treatment with clinic administered 340B medications. See Appendix F.
- Medical Center considers these clinics pure 340B areas, as all providers are employed or contracted by Medical Center, and all patients are eligible receiving treatment at a DSH location.
- Clinic stock medications are purchased directly on a 340B account. These patient encounter medication administrations are excluded from the mixed-use RxWorks data feed. A record of these medications used can be found in the admission-discharge-transfer system: Invision.

7. 11-DIGIT NDC REPLENISHMENT

7.1 Medical Center replenishes inventory at the 11-digit NDC level as a standard practice for Outpatient Retail and Mixed-use Pharmacy.

7.2 In exceptional circumstances, when 11-digit replenishment is not possible, Medical Center may choose to replenish at the 9-digit NDC level. Auditable records demonstrating the appropriate amounts are replenished from the same manufacturer are maintained.

7.3 Mixed-Use Pharmacy procedure for 11- to 9-digit replenishment.

- Verity AutoSplit 340B is the split-billing software and accumulator.
- Drug/dose dispensing file is based on CDM charge code.
- Via the CDM, different NDCs are linked into one accumulator, for example an 11- digit NDC number that is discontinued, is replaced with 9-digit NDC number match with Verity.

8. **TRANSFER OF INVENTORY: 340B to non-340B.** Transfers of inventory are discouraged. Only in the case of emergency medical situations or critical drug

shortages will drugs be transferred from a 340B inventory to a non-340B inventory. In the case this happens, the following procedures will be used:

8.1 Medical Center will only transfer 340B inventory within its own pharmacies.

8.2 Medical Center staff identifies an emergent patient need and available inventory on shelf.

8.3 Medical Center immediately involves a Senior Clinical Pharmacist supervisor, or higher, in decision-making process.

8.4 Medical Center staff and/or supervisor notify the pharmacy buyer to immediately purchase the replenishment item on the appropriate account.

- Replenishment item has the same NDC and quantity that was borrowed.
- If the product cannot be replaced/replenished at the 11-digit level then it will not be transferred.

8.5 Replenishment purchase orders are identified by naming convention: the area to replenishment (inpatient or outpatient), replenishment, and the purchase order date, e.g.

- For inpatient: IPREPDDMMYY.
- For outpatient: OPREPDDMMYY.

8.6 Reconciliation is completed the next business day when the order is received.

8.7 Log will be maintained documenting the inventory transfer, NDC for appropriate 11-digit replenishment, and rationale for actions.

9. **COMPLIANCE WITH GPO PROHIBITION.** Medical Center does not use a GPO to purchase covered outpatient drugs. To comply with this regulation Medical Center maintains the following account types:

9.1 Outpatient Retail: 340B and WAC.

9.2 Inpatient/Mixed Use: GPO, 340B, and WAC.

9.3 Hospital based clinics: 340B.

9.4 Medical Center maintains auditable records of distinct purchases to demonstrate compliance.

9.5 Exceptions are:

- Hospital cannot access a drug at the 340B price or WAC price to prevent disruptions in patient care.

- GPO drugs were provided to an inpatient whose status is subsequently changed to an outpatient by a third party (such as an insurer or RAC).

10. **PREVENTION OF DIVERSION.** Medical Center enacts measures to prevent diversion of 340B drugs to ineligible patients. To comply with this regulation Medical Center utilizes the following measures:

10.1 Outpatient:

- Patient, provider, and site eligibility tests.
- Implementation of commercial software Verity AutoSplit, which employs logic to prevent accumulation for 340B purchases by evaluation of dispense data, prescriber eligibility data, and patient registration data.

10.2 Inpatient/Mixed Use:

- Patient drug/dose dispenses are captured through end-of-day processing and collected within the hospital admission-discharge-transfer system: Invision.
- Charges are batched, and separated or categorized by patient status: inpatient and outpatient.
- The categorized batch passes to Verity accumulator, and purchases will split based on accumulation:
  a. Inpatient accumulations: split to GPO.
  b. Outpatient accumulations: split to 340B.
  c. Charges without accumulation: purchased on WAC.

10.3 Medical Center maintains fully auditable purchasing and dispensing records that document compliance with requirements including the prohibition of drug diversion.

11. **PREVENTION OF DUPLICATE DISCOUNTS.** In order to prevent the "duplicate discount", Medical Center uses the appropriate code on MediCal claims. The following codes are used:

11.1 Mixed Use, Clinics, and Physician Administered Drug claims: "UD" modifier.

11.2 Retail Pharmacy claims: "08" in Basis of Cost Determination Field.

11.3 The UD modifier and the 08 code inform DHCS that a 340B purchased drug was used for the claim. See Appendix L.

12. CONTRACT PHARMACY

12.1 Medical Center has contracted with Verity to facilitate both the design and implementation of the 340B contract pharmacy program. Medical Center uses a replenishment model for contract pharmacy services.

12.2 On a daily basis, Medical Center sends to Verity:

- An updated list of eligible 340B prescribers within the credentialing database from the previous 365 days.
- An updated list of eligible 340B patients within Medical Center's medical records department from the previous 365 days.

12.3 On a daily basis, the contract pharmacy sends to Verity:

- A daily dispense history, indicating the patient (with identifiers), the medication dispensed and quantity, the prescriber, and the payer type.

12.4 Upon receiving data from Medical Center and the respective contract pharmacy, Verity matches up previous dispenses with eligible 340B replenishment orders.

12.5 Upon eligible 340B dispenses accumulating to a unit of issue package size, Verity, on behalf of Medical Center and the contract pharmacy, will place the 340B replenishment order through the distributor.

12.6 On a monthly basis Verity will produce a detailed report indicating transaction specifics for auditing purposes.

12.7 Medical Center staff examines audit reports monthly, and reports to the 340B Oversight Committee.

13. COMPLIANCE REVIEW and RECOMMENDED MONITORING

13.1 Medical Center performs monitoring on periodic intervals including: daily, weekly, monthly, quarterly, and annually.

13.2 See Appendix J.

14. REPORTING 340B NON-COMPLIANCE

14.1 Potential violations or breaches identified through internal self-audits, independent external audits, or otherwise are brought to the Compliance Officer for review.

14.2 The Compliance Officer may convene review with the 340B Oversight Committee and the Compliance Oversight Committee to oversee this process, review situations, and make decisions about meeting the material